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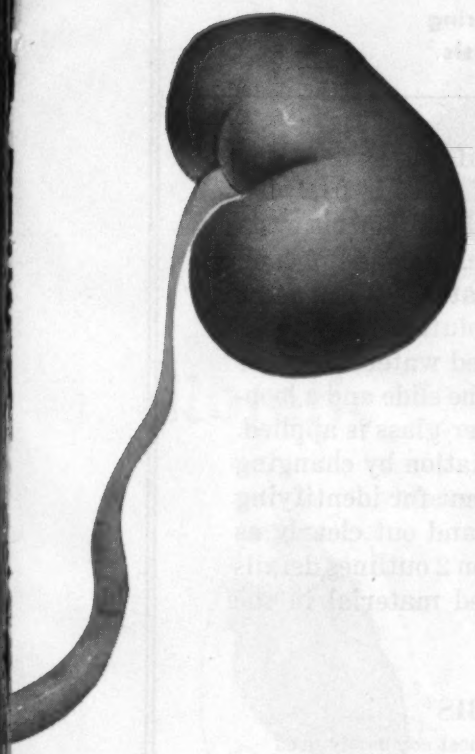

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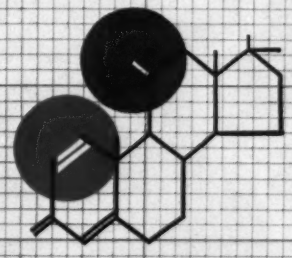

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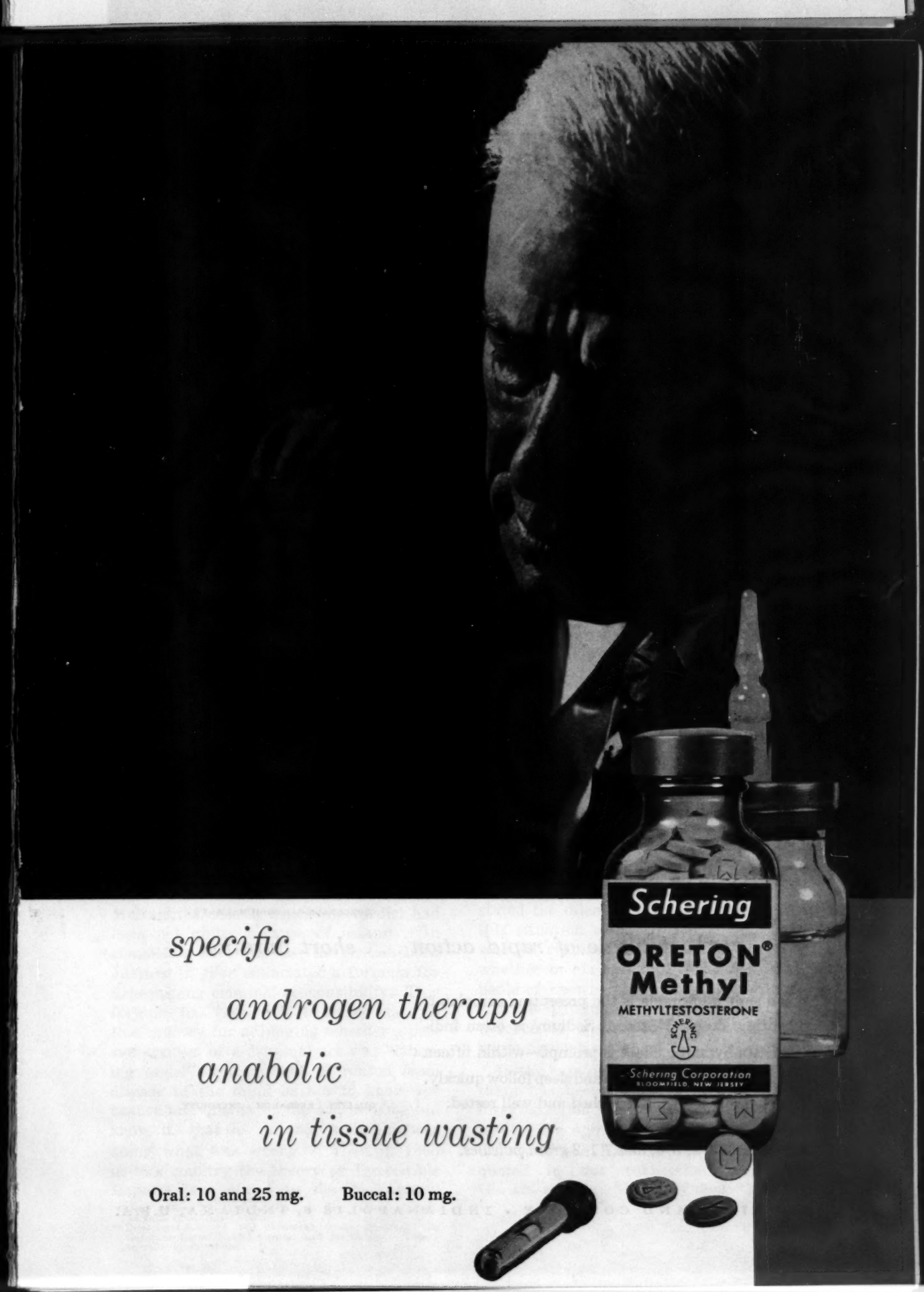

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"INSANITY" AS A DEFENSE IN CRIMINAL CASES*

M. A. TARUMIANZ, M.D.,**
Farnhurst, Del.

In the long history of judicial procedure in Western Culture the number of times "insanity" has been offered as a defense in criminal cases is undoubtedly relatively small. The sensation which such cases causes, however, and the publicity given them through the modern instruments of communication — newspapers, radio, and television — assign to this defense, even in a few cases, an exaggerated importance and frequency in the mind of the public.

The defense of insanity is not new in the history of criminal cases. During the reign of Edward I (1272-1307), insanity was admitted in the courts of England as an excuse for crime. During the time of Edward III, about the middle of the fourteenth century, "absolute madness" was accepted as a complete defense in criminal cases. Following this theory of "absolute madness" the mind of insane persons was compared to that of a wild beast. From this theory came the test of "raving madness." A person whose mind was that of a wild beast could not know right from wrong.[1] The "raving madness" test was elaborated in the famous McNaghten case in which the verdict had been not guilty because of insanity. In connection with this case the British Lord Justices in 1848 enunciated a formula for determining criminal responsibility. This formula has been used in every state in this country for adjudging whether a person accused of a criminal act was "laboring under such a defect of reason from disease of the mind as not to know the nature and quality of the act, or if he did know it, that he did not know he was doing what was wrong."[2] Then in 1868 in this country the theory of Irresistible Impulse was added to the McNaghten Rules.[3] In the case of State v. Jones in New Hampshire in 1871 the McNaghten Rule was repudiated as a test of criminal responsibility. In this murder case the jury was instructed: "If the defendant killed his wife in a manner that would be criminal and unlawful if the defendant were sane, the verdict should be not guilty by reason of insanity, if the killing was the off-spring or product of mental disease in the defendant."[4] This decision of the New Hampshire court is now known as the New Hampshire Rule. This rule implies guilty intent as well as a prohibited act as fundamental in criminal responsibility.[5]

Toward the end of the eighteenth century psychiatrists were asked to assist the courts by giving opinions on whether a defendant was capable of knowing right from wrong or whether the defendant knew that what he was doing was wrong. Discontent with these formulations has been voiced by leaders in American psychiatry for a long time.

Opposition has come not only from psychiatrists but from learned representatives of the legal profession. The opinion on this matter writen by one of the members of this panel, Chief Judge Biggs, in the case of Smith v. Baldi is frequently quoted. Judge Biggs clearly and briefly stated the dilemma of the psychiatrist in this situation when he wrote: "The law, when it requires the psychiatrist to state whether in his opinion the accused is capable of knowing right from wrong, compels the psychiatrist to test guilt or innocence by a concept which has almost no recognizable reality."[6]

In the case of Durham v. United States there has been considerable evidence of dissatisfaction with "the right-and wrong test". The opinion of Professor Sheldon Glueck of the Harvard Law School was quoted in this connection. Professor Glueck stated: "It is evident that the

* Read before The Judicial Council, 3rd Judicial Circuit, Atlantic City, July 7, 1955.

** Superintendent of the Delaware State Hospital, the Governor Bacon Health Center, and the Delaware Colony for the Feebleminded.

knowledge tests unscientifically abstract out of the mental make-up but one phase or element of mental life, the cognitive, which, in this era of dynamic psychology, is beginning to be regarded as not the most important factor in conduct and its disorders. In brief, these tests proceed upon the following assumptions of an outworn era in psychiatry: (1) that lack of knowledge of the 'nature or quality' of an act (assuming the meaning of such terms to be clear), or incapacity to know right from wrong, is the sole or even the most important symptom of mental disorder; (2) that such knowledge is the sole instigator and guide of conduct, or at least the most important element therein, and consequently should be the sole criterion of responsibility when insanity is involved; and (3) that the capacity of knowing right from wrong can be completely intact and functioning perfectly even though a defendant is otherwise demonstrably of disordered mind."[7]

The decision of the Court of Appeals for the District of Columbia, enunciated on July 1, 1954, by Judge Bazelon with the concurrence of Judges Edgerton and Washington is indeed a milestone of progress in the effort of courts to deal justly with the criminal who is mentally ill. Judge Bazelon stated, "The rule we now hold must be applied on the retrial of this case and in future cases is not unlike that followed by the New Hampshire court since 1870. It is simply that an accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect."[8]

The problem of dealing with crime is a great and very serious one in our modern life. Although we as a nation are dedicated to the principle of "justice for all" as one of the fundamental rights of our citizens, when someone interferes with our individual rights we find it hard to be dispassionate. Also, there is still inherent in the public mind and unfortunately at times in some of the courts in this country, the idea of retribution, that the wrong-doer must "pay" for his crime rather than that the rehabilitation of the offender should be sought whether by fines, probation, incarceration or other penal process. Robert A. Feary, an officer of the United States Department of State, in discussing the concept of criminal responsibility, expressed the following view regarding our system of penology. "From time immemorial the antidote to crime has been punishment, conceived as serving the double function of inflicting deserved retribution on the evil-doer and of deterring others."[9]

Dr. Glueck also gave the following very convincing opinion concerning the need which people experience for the punishment of others. "This is the unconscious need that the members of a society feel for a reenforcement of their own restrictive mechanisms through the medium of the example of others. Thus we have the seemingly bloodthirsty payment in kind for the wrong done, an eye for an eye, a life for a life, as in the ancient 'lex talionis'. An integral part of this attitude is the concern expressed that the offender may escape the punishment he deserves."[10]

Crime has not been understood properly. Who is a criminal? "A criminal is a man who is unable to subjugate his personal desires for the good of society. This inability to withhold the realization of personal desire until some future date, or to give it up entirely for the welfare of the group, may be considered an abnormality and is a primitive reaction to life situations."[11]

Another psychiatrist in defining crime wrote: "Crime is one of the many possible expressions of human motives. In general, the criminal is one who has no inhibitions in acting out his unconscious impulses; he is in conflict, perpetually, with others and with himself."[12]

There are numerous and different kinds of crimes, but basic in the etiology of crimes is fear. Fear must be distinguished from terror which may be a state of intense but short-lived fear caused by the use of violence against an individual. Fear may be a basic, prolonged reaction stemming from deprivation and other psychological trauma in early childhood and enduring throughout life unless the victim of fear is helped to understand

himself and to have experiences which serve to dissipate his fears. Whether we are dealing with "petty stealing to avert starvation or actual felony to maintain a certain standard of living, the motivating force is the same, viz., fear of losing what the individual ego feels is necessary for successful living".[13] "The early feeling of insecurity may produce and often does, an adult who fails to reach the highest possible development because of a fear of giving up even the slightest amount of security which is present in order to realize higher ambitions. If the child is aggressive he may attempt to physically harm the object which has endangered the fundamental feeling of security . . . Stealing, running away, or other attention gaining mechanisms may be used and may become a permanent part of the personality picture developing almost habitual aspects . . .[14]

One of the most serious crimes with which both the law and psychiatry must deal is murder. Murder may be expressed in many ways. "Generally speaking, it seems that aggressive behavior will ensue when ego strength is insufficient to combat the destructive forces derived from early oral aggression".[15]

A very shocking kind of murder is that performed sadistically. The cruelty inflicted on the victim with subsequent death is an end in itself. There is considerable evidence that cruelty is sexually motivated. The sense of mastery which the sadistic murderer has over the fear and helplessness of his victim is stimulating to the murderer who long may have suffered from feelings of inadequacy. The majority of sadistic murders are committed by younger criminals.[16]

A quite common type of murderer is one whose victim is the person he most loved. Such a murderer is often suicidal himself and has shown symptoms of a depressive psychosis before the homicide. Suicide is frequently seen as a form of aggression against the self. The depressive psychotic person does violence against some one who is almost a part of himself. After the homicide the wish for suicide may be lost as the psychotic has in a sense already killed himself in destroying someone whom he may have seen almost as an *alter ego*.[17]

Murder frequently symbolizes suicide. The urge to destroy oneself is turned outward instead of inward and is channelled into an aggresive act against some other person. Especially in a mental illness like schizophrenia murder may serve as a defense against the ego disintegration occurring in the mentally ill person. There is much evidence that in the schizophrenic person feelings of rage play an important part. This rage, stemming from frustrations during early years, if not discharged, builds up in the schizophrenic. He becomes progressively isolated and alienated from his fellows and at the same time, through projection of his feelings toward others, sees an increasing number of enemies and threatening forces against him. If the schizophrenic's ego is not destroyed, he must discharge his hatred in some manner. After a period of unbearable tension and extreme anxiety, manifested through depression or agitation with anger playing an important role, the more active type may commit murder in a desperate attempt to prevent the psychosis. "Only an aggressive act of great magnitude will suffice, the choice depending on the relative strength of inhibitions, social sense, etc."[18]

Cases in which a parent murders a child are usually symbolic of suicide through a process in which the parent sees the child as himself. Psychiatric examination in cases of child murder by parents has shown the murder as not primarily an expression of conscious or unconscious hatred against the child. Schizophrenic and manic-depressive psychotic mothers especially, often project their symptoms on to their children. Through this process, "the child becomes analogous to an organ in the mother's body." The mother's suicidal urge may be converted into a drive to kill both the child and herself. However, after killing the child the mother may feel relieved of her symptoms, which she believes she has destroyed in the child. A mentally ill mother may have a desire for suicide to escape from the vicis-

situdes of life whether these are real or imagined, and the child represents a part of her personality through which she can escape.[19] Of course some aggressive tendencies against the child may exist, as in the case of a mother who lost her first child or one whose offspring has resulted from seduction.

Another very serious type of offense is the sex offense which may or may not eventuate in murder. The murder of a raped victim may result from the intense fear reaction after the gratification of uncontrollable sexual impulses. Dr. Ben Karpman described the case of a youth who suddenly stabbed a girl sitting in front of him in a movie. This boy had an abnormal sex drive which impelled him to torture women to death.[20]

In the case of William Hierens, the seventeen year old University of Chicago student who in 1947 murdered three persons as well as committed more than 500 burglaries, the motivation was not overt sex gratification, as through rape, but the fetishism of collecting women's undergarments. The history of this youth revealed that at the age of nine he had begun to steal women's underclothes. At first he could have sexual orgasms by wearing these garments. This gave way to sexual stimulation through the excitement of stealing the garments. After Hieren's arrest he was found to possess trunks full of women's sheer underthings. He explained his murders as his efforts to escape detection on being discovered burglarizing.[21]

That unconscious motivation figures in many crimes is attested to by Dr. Bernard Glueck, who found that "68 percent of the male sex offenders examined deny any, or at most, partial sexual gratification at the time of the offense. The most common motivation is the attempt to prove that they are sexually potent, that they are not castrated and that their sexual function is normal. This need arises from the very intense feelings of genital inadequacy and impotence suffered by these men.[22]

A series of cases in the state of Delaware came to my attention several years ago when I as State Psychiatrist and my staff at the Mental Hygiene Clinic were requested by the court to examine eleven young men, all eighteen or nineteen years of age, who had been in a number of predatory acts in a small town in the state. These youths represented a very complex problem. They were "individuals from some of the better homes who have apparently had opportunity for social training . . . individuals of better than average intelligence in every case . . . individuals who appear to be, at least superficially, outgoing and socially inclined, and . . . most, if not all, of these young men went to a school which is considered to be a very good one." The problem was "also complicated by the fact that in very few, if any, of these cases" was "the monetary consideration an important factor and also because in most, if not all, the cases, the thrill or excitement involved in the predatory act was an important factor."[23]

Our study of these youths showed that "none of them, not even the 'leaders', could be stated to have a satisfactory masculine indentification (this in spite of the fact that most of them took part in athletics). There was considerable evidence that the mothers, in most of these cases, were the dominating characters in the families and the fathers played secondary roles. In some of the cases, the fathers were either decidely passive, too busy, or or perhaps were too disinterested. In some of them, the permissiveness of the parents itself functioned as a sign of disinterest rather than as evidence of acceptance."

It was further noted "that almost every member of the group spoke of being 'bored' at school, and at the same time, the teachers complained of the negative behavior of the individual. It would seem that in spite of the athletic program at school, these young men were not sufficiently challenged to keep their interest active in school and to challenge their better-than-average intelligence.[24]

The legal requirement of establishing the mental competence of the accused at the time of the anti-social act, and whether he was therefore criminally responsible for the crime of which he was accused,

has caused much confusion and delay in the adjudication of such cases. Another result of this requirement, which until recently has been in force in 29 states with 14 additional states using this formulation with the theory of irresistible impulse, has been the great cost to the state of prolonged litigation such as appeals and re-trials.

A case in which the matter of criminal responsibility was involved is that of People v. Caruso.[25] The defendant's infant child had died. At the time of the death it appeared to the defendant that the attending physician had laughed at what had happened. In grief and rage the father choked the doctor who fell to the floor. Then the father took a knife and twice stabbed the doctor, killing him. Certainly the defendant had the intent to kill, but he had not premeditated this or deliberated on the means. In his overwhelming grief and uncontrollable rage the defendant did not know what he was doing. The verdict of murder in the first degree was reversed and Caruso was granted a new trial.

The role of the psychiatrist in court should be to give an opinion on the mental condition of the defendant. The psychiatrist should not be required to fit his testimony into a formula determining whether the defendant knows right from wrong or whether, knowing right and wrong, he knew that this particular act was wrong. As has been pointed out already, psychiatrists have had much experience with mentally ill persons who knew right from wrong and were not possessed by an "irresistible impulse" but were quite incapable of controlling their behavior.[26]

The case of Monte Durham[27] is a very interesting one, especially since he had been hospitalized as a mental patient prior to his second conviction which was for passing bad checks. He was already on probation from violating the National Motor Theft Act. He was treated at St. Elizabeth's Hospital for two months after his first commitment, for 15 months after the second, and soon after completing his sentence for the conviction on passing bad checks, he violated the conditions of his release. Again he was referred to the District Court for a lunacy hearing and adjudged of unsound mind. After readmission at St. Elizabeth's in February 1951, he was again discharged in May 1951. Scarcely two months later, on July 13, 1951, Durham committed the criminal act of housebreaking, the offense which led to the appeal. From this appeal has resulted what is now being called in the literature "The Durham rule."

One other point which should be made is the advisability of psychiatric examination of a defendant before trial rather than after trial. Especially is this important when a defendant is accused of a serious offense. In the case of Durham v. United States the fact that Durham's mental condition before trial had not been determined was an important point in the appeal. The defendant's mother testified to pre-trial behavior in her son which seemed indicative of mental illness, but the court had no official evidence on this point. The trial court had rejected Durham's plea of insanity stating in part: "I don't think it had been established that the defendant was of unsound mind as of July 13, 1951, in the sense that he didn't know the difference between right or wrong or that even if he did, he was subject to an irresistible impulse by reason of the derangement of the mind . . . There is no testimony concerning the mental state of the defendant as of July 13, 1951, and therefore the usual presumption of sanity governs. While if there was some testimony as to his mental state as of that date, the burden of proof would be on the Government to overcome it. There has been no such testimony, and the usual presumption of sanity prevails."[28]

In 1929 the Delaware Legislature, at the time it created the Mental Hygiene Clinic, provided that the State Psychiatrist and his staff at the Mental Hygiene Clinic should "observe, examine, study, and treat any person charged with any offense in, or subject to any court within the state, when requested to do so by a judge or judges thereof."[29] It is our custom to examine before their trials all persons charged with homicide or other serious

offense. In fact the courts of the state have considered crime as possibly resulting from a personality defect with definite mental aberrations. Crimes included in this group are cases of assault and battery, indecent exposure, homosexuality, assault on children, obscene letters, arson, and similar types of offenses.[30] It has been the practice of the courts in the state of Delaware to adhere to the New Hampshire Rule rather than to the McNaghten. The courts have accepted the opinion of the State Psychiatrist regarding the mental condition of an offender. They have accepted the idea that a defendant may know what is right or that his particular act is wrong but because his thinking may be so blunted or distorted because of a paranoic condition, or some other mental condition, he can no longer act in accord with what he knows is right.

The Durham Rule, which Judge Bazelon and his associates have given for the guidance of the re-trial of Monte Durham and other similar cases, should eliminate some of the difficulty which psychiatrists have experienced in serving the courts. It should also make the testimony of psychiatrists more useful to the courts, for there should no longer exist such a dichotomy as legal insanity and medical insanity.

This decision should make possible more effective treatment of offenders whose aberrant conduct has been due to mental disturbance. Instead of being incarcerated in penal institutions to "serve time" in paying "their debt to society" and at the expiration of the time perhaps automatically being returned to the community to continue their aberrant behavior, these persons will be confined for treatment for as long a period as their conditions require. The states will be forced to provide facilities for the treatment and custody of such offenders, recognizing them for what they are — mentally sick persons.

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THE EMANCIPATION OF THE MENTAL HOSPITAL

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The psychiatrist in a mental hospital finds himself in many ways in the paradoxical situation of attempting treatment in an anti-therapeutic climate. The conventional hospital for psychiatric patients is a state institution, requires commitment, is located outside of city limits and imposes on the patient a social order of restriction, dependence and disindividualization. People in general continue to equate mental illness with social dangerousness and demand protection in form of security policies. There are mental patients who need to be restricted, as there are contagious patients who need to be isolated. For the latter patients a special unit attached to the general hospital serves this purpose. A somewhat similar arrangement would seem logical for mental hospitals but meets with many obstacles and difficulties. Some of them are of more recent origin than is usually realized.

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The Centennial Issue of *Mental Hospitals*, published recently in its original form of 1855, must have profoundly surprised many who attribute every progress to the present. In this issue which was published when the St. Elizabeth's Hospital in Washington, D.C., was opened are comments which deserve to be quoted. We read this about the opinions of the first superintendent; "The organization of the institution is based upon the latest principles of moral management with as little restraint as is practicable in managing this difficult class of persons. Bed straps, muffs and mittens exist but are seldom employed and bed straps only are applied to females. Dr. Nichols believes that the condition of the patients is dependent upon the character of their attendants."

Discussing what was then called "moral treatment" a prominent psychiatrist from Scotland stated: "The character of the moral management is activity without excitement, progress and the combination of self-government with the appeal to the intellect and sentiments. There is always something to expect, to prepare for; some anticipation, or some retrospect. Patients are participators in every arrangement. They are identified with the recreations, as well as the labor of the community. They are led to understand that each progressive step is not merely for them but by them."

Finally, the superintendent of a large New York "Asylum" makes this comment which must seem strangely up-to-date: "In the lunatic hospital as in society and in the state, the individual must be prominent. The very disease for which he is admitted tends ultimately to destroy individuality. For this reason, his identity must be preserved, his just claims recognized, his self-respect encouraged, and his mind incited to useful or refining occupation."

Being confronted with such views, it is quite obvious that neither public opinion nor medical practice have fulfilled the hopes of 1855. It is not my intention to analyze the factors which retarded the progress. I want to discuss some developments in clinical and social psychiatry which promise real advance toward the emancipation of the mental hospital.

Perhaps the most feared and extraordinary aspect of the mental hospital atmosphere has always been the element of disturbed and uncontrolled behavior of mentally ill patients. While the number of patients with such changes in social conduct is much smaller than is generally assumed, one can hardly deny the fact that noise, destructiveness and violence contaminate the climate and deprive other patients of a sense of tranquility. For this reason, it has never been possible to dispense with restrictive measures designed to keep disturbed patients reasonably controlled. Isolation rooms, mechanical restraints, continuous baths, cold packs and empty wards devoid of destructible objects were the answer. In recent years, maintenance electro-convulsive treatments amounting to hundreds of treatments per patient were added. With the introduction of Chlorpromazine and Reserpine, however, marked changes have taken place which, for the first time, permit the abolition of these restrictive measures and make possible a reorganization of clinical management. Our clinical experiences, results and opinions on the effectiveness of these drugs, will be reported elsewhere.

Research programs with both drugs are still in progress. Therapy with Chlorpromazine, however, has been quite extensive and primarily responsible for the following changes. Mechanical restraints have become unnecessary. Certain patients, who because of chronically disturbed behavior had been in one form of restraint or another for five years and more, have resumed regular social activities due to Chlorpromazine. Destructiveness has ceased to be a daily occurence. The department of hydrotherapy, previously highly active on all admission and disturbed wards, has been discontinued. Electro-convulsive and insulin treatments have been replaced to a considerable extent by drug therapies. What is most important, however, is the fact that these drugs bring about a harmonization of agitated, tense, and disturbed patients without clouding consciousness. This means

that psychotherapy and social reactivation can be initiated quite early during the course of treatment. It is, therefore, apparent that the passing of the disturbed-ward atmosphere has far-reaching effects on the organization of the hospital. But it is equally certain that a general change in thinking is necessary in order to take full advantage of these changed conditions. The greatest danger to the recovery of the patient remains the social isolation imposed by the general belief that every mental patient should be kept hospitalized until fully recovered.

One should not overlook that in mental disorders as in physical diseases treatment must often be directed at functional restoration rather than cure. A patient with rheumatic heart disease can leave the hospital if treatment has been effective in returning him to a state of compensation. We know today that hospital discharge rates of schizophrenic patients were substantially higher 50 years ago because psychiatrists were afraid of the demoralizing influence of prolonged hospital life on the patient's capacity for social living. What is not generally recognized today is the degree to which overcautiousness interferes with a favorable outcome of mental illness. Certain inconsequential delusions are of the order of valvular murmurs: they constitute pathology but do not require continuous treatment. The danger of over-treatment and excessively long hospitalization are undoubtedly problems which must be earnestly reconsidered.

Equally important are recent developments in social psychiatry which were initiated in England. A few months ago, I had the opportunity to visit psychiatric hospitals in England and on the continent. I had heard much about the Warlingham Park Hospital. This is a mental hospital near London which is comparable to the average state hospital in this country. My visit there was a very striking experience indeed. While the hospital itself is old, its social management is courageously modern. There are no locked wards. All patients leave the wards during the day and are busily engaged. Principles of self-administration are stressed as much as possible. The patients mix freely on the grounds. There is no separation of the sexes in the dining halls. Resentment against the hospital administration is minimal since there is little interference with the patients' personal matters. Some patients cook their own meals, others decide how to decorate the rooms or what flowers to plant in the gardens. This delegation of authority and responsibility is very effective in strengthening the patients' initiative and stimulating social attitudes. Even psychotic patients are permitted to enter the hospital on a voluntary basis.

In the beginning of this regime, there was much public resistance and criticism, particularly in case of escapes. Gradually, however, people in the community began to understand the new purpose of the hospital. Volunteers were encouraged to participate in all hospital activities and wives or husbands of patients were permitted to be present at group therapy sessions. The doctors divide their time between hospital duties and community services. They visit patients in their homes, hold clinics in general hospitals and organize "social clubs" for former patients. The general emphasis on group therapy and group responsibility is of great therapeutic significance since it creates a social order in which patient, family and community discover common interests. This is an important lesson to learn.

The successful social reform of the mental hospital is the joint responsibility of the medical profession. It can never be the sole task of psychiatrists. The availability of new drug therapies makes the expansion of psychiatric services in general hospitals more plausible than ever. The disappearance of turbulence and disorder in mental hospitals will help to dispel public aversion. We must be ready to recognize that the management of mental illness demands radical reforms of which the emancipation of the mental hospital is the most vital one.

THE SEX OFFENDER
His Prognosis with Treatment

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The problem of the "sexual offender" has, within recent years, been given a considerable amount of attention throughout the United States. Various states have set up commissions and facilities for the study and care of these individuals and the public has been aroused particularly by the so-called sexual crimes.

This paper will consider twenty-one such consecutive cases referred to the Delaware State Hospital, Mental Hygiene Clinic, for examination and treatment.

It should be noted that the entire list includes only three in which children were directly involved and that in none of these was violence included. There were five cases where the problem was essentially overt homosexuality. The rest were voyeurs and exhibitionists and a few involved coprolalia or aggressiveness through the use of the telephone.

It might further be stated that of all the cases treated, only one showed recidivistic tendencies and only one was required to return for further treatment even though the treatment period was short in all the other cases. The writer, of course, points out that this may only mean that if these individuals did return to their former patterns of behavior, they did not again fall into the arms of the law. The fact that this is a small state with a fairly static population tends to give the offenders the benefit of the doubt.

It should also be pointed out that by far the greatest number of these individuals were male and that a considerable portion of them were married.

This writer's clinical impression bears out the impression of Palson and Abrahamson (J. of Nervous and Mental Diseases, Vol. 119 No. 2, Feb. 1954), that wives or mothers of the offenders played a significant role in the personality dynamics of the offenders. Also, in almost every case the individual gave the impression of being of about average intelligence and generally passive individuals, many of less than average stature — and by far the greatest proportion between 20 and 35 years old.

In only two cases were more than one form of sexual deviation involved. One an adolescent boy indulged in fetishism which included the larceny of women's clothes and of girls purses at school and exhibitionism; and one a well developed male who indulged in both exhibitionism and voyeurism.

Treatment in most cases was of short duration, less than 15 hours in most of them and with apparently satisfactory results. Analysis was not attempted. Many of the cases were able, under treatment, to express hostility toward pertinent females in their lives.

One such case will be discussed briefly to point up the personality factors involved and its treatment.

P., a white male, age 35, married approximately one year — no children, industrial engineer, World War II veteran, honorable discharge. P. was referred to Mental Hygiene Clinic because of his compulsion to telephone unknown women and to make suggestive remarks to them. He was arrested when he repeatedly drove his car around the home of one of his victims. Once the police started to question him he quickly confessed and provided a list of the women he had called. His statement regarding getting caught was "I was relieved."

The history revealed that his father had been arrested for a similar charge a number of years before. Further social history obtained from P. was that his father was a fairly serious alcoholic, that his mother had almost always worked and that father had worked when he was sober. Mother was the dominant character in the family and her continuous nagging of the alcoholic father was very upsetting to P. As a result P. was often tempted to strike his father but never did so. His statement — "I once spit into his face" — gives some concept of his state of tension.

P. states that he himself was a very good boy, regularly turning all of the proceeds of his newspaper route and small business over to his mother. Once when

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he was employed he turned his check over to his mother and it was only when his mother told him that he found out he had received a salary increase.

Upon his return from war service he again moved in with his parents, and resumed the same pattern of behavior. He was quite upset when he learned that his father's foolish speculations had cost him all of his savings, but to express these feelings openly would endanger his dependent status and so he did nothing. Later, when he married he continued to live with his parents while rationalizing his need to do so.

During the course of his therapy P. revealed anxiety regarding his wife's attitude toward him. He was extremely grateful when she did not immediately divorce him when he was arrested, and he spoke of putting "blinders" on himself to avoid looking at other women in the presence of his wife.

It was soon obvious that he identified his wife with his mother and that he felt he must remain passive and conforming in his relationship to her. It was also soon obvious both to the therapist and the patient that he identified himself with his weak father and only when he recognized his father's dissipation as a technic of retaliation against the aggressive and castrating mother that he recognized the displacement of hostility and developed insight into his own behavior. Following this the patient was able to move out of his "mother's house." He became more accepting of his father and his relationship to his father improved considerably.

He also spontaneously reported an improved relationship to fellow employees. A markedly increased degree of self esteem and aggressiveness was noted.

Similar results were obtained with several exhibitionists and with two of the cases of pedophilia.

Results with overt homosexuals obviously were not as successful in terms of removing the deviated behavior, but improvement in personality was noted in a few.

In summary, this writer would point out that the less malignant forms of sex deviations are readily treatable and that the usual pessimism in managing these cases is unwarranted.

EFFECT OF CHLOPROMAZINE MEDICATION
On Children with Severe Emotional Disturbance

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At the Governor Bacon Health Center some 150 emotionally maladjusted children between the ages of 4 and 16 years are in residential treatment. The emotional problems of all of these children, evaluated prior to admission, were considered too severe to be treated on an outpatient basis. A number of the children come from homes broken by death, divorce, or the absence of one or both parents because of physical or mental illness. Some of them are in the custody of social agencies and have known more than one foster home. In cases in which the homes are still intact, most of the children in the Center have been severely, if not completely, rejected by the parents or parent-substitutes. Bewildered and hurt by conditions as well as actions and attitudes of others which they have not understood and with which they could not cope, these children have acted out their fears and resentments in aggressive and anti-social behavior, or they have developed neurotic mechanisms such as bed-wetting, nail-biting, facial tics and hysterical symptoms. A few have withdrawn from reality, escaping their problems in fantasy and through bizarre behavior.

The child who is acting out his emotional problems frequently is hyperactive, unable to perform satisfactorily in school, aggressive and hostile to peers and/or adults, is truant and incorrigible. His anti-social behavior may include theft, lying, destruction of property. Such a child may resist efforts to reach him, particularly the efforts of the adults in his environment.

The Center, at present, also provides for the children of the state care and treatment for cerebral palsy, epilepsy, and cardiac diseases. Frequently children of these three units present severe emotional

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problems in addition to their physical condition.

The staff is constantly challenged to find ways in which to help the children adjust to their environment. At times to protect them from doing physical harm to themselves or to others it has been necessary to use sedation, isolation, or occasionally restraint.

In 1954, after the publication of Lehmann and Hanrahan's study of the controlling effect of Chlorpromazine (10-(3 dimenthylaminopropyl)-2-chloropenothiazine hydrochloride) on psychiatric patients and the findings of Altschule, Bower, and Cook, chlorpromazine was given to nine boys at the Center who were acutely disturbed and were chronically acting out their problems. With the initial use of chlorpromazine on maladjusted children, Gatski observed that these severely disturbed acting-out children became more manageable, more communicative, more cooperative, and established better rapport with therapists, improvement being evident within a week after medication with the drug was begun and continuing as long as the children received the drug. These findings led to further studies of the effect of chlorpromazine on severely disturbed acting-out children in the Center population.

In the period between January and June, 1955, sixteen children at the Center were receiving thorazine. This group comprised fourteen males and two females. The ages ranged from 6 years-4 months to 15 years-5 months. Among the sixteen children are three from the cerebral palsy unit, two from the epileptics unit, one from the cardiac-bedrest group, and ten from the cottage (maladjusted) group. All of these children were hyperactive, intractable, hostile and aggressive. Some were subject to severe temper tantrums, during which they kicked, screamed, threw articles, sometimes banged their heads or otherwise hurt themselves. One of the cerebral palsied children emitted piercing screams for prolonged periods when he could not have his way or receive the attention which he constantly craved.

The thorazine dosage administered to the children in this group has varied from 10 mg. given four times daily (q.i.d.) to 250 mg. four times daily. Two children have received 25 mg. three times daily (t.i.d.) two 25 mg. q.i.d., three 50 mg. q.i.d., one 50 mg. t.i.d. Three have had alternating doses of 50 mg. b.i.d., and 25 mg. b.i.d. Two received 10 mg. q.i.d. One child who suffered psychotic episodes was controlled with doses of thorazine which were started at 75 mg. q.i.d., and gradually increased to 250 mg. q.i.d.

Personnel who evaluated the effect of thorazine medication on these children noted definite positive change in twelve of the children, no change in two, "not much change" in two. The twelve in whom positive behavior changes were seen were reported as being more quiet, less aggressive, easier to manage, less irritable and threatening.

The side effects observed were drowsiness, which occurred during the first few days of thorazine medication and one case of pseudo-parkinsonism in the patient receiving 1000 mg. daily. While he was in isolation and under thorazine treatment the psychologist reported "The effects of treatment could be noted in his slight drowsiness and the monotony of his voice, unmodulated by emotion. There was postural rigidity and his graphic productions showed evidence of a fine tremor."

A brief review of several case studies of these children will point up more vividly the changes in behavior which seem typical in the emotionally maladjusted children who have been treated at the Center.

B.R., a 10 year old white boy was referred for residential treatment after six months of individual therapy at the Mental Hygiene Clinic. This child had experienced insecurity and rejection from birth. There was a younger sister and an older illegitimate half-brother, the child of the mother. The patient was unwanted and rejected by his mother. The father undertook the care of this child and his sister. After the parents separated this boy and his sister went to different foster homes arranged by their father. The

mother interfered and would remove the children at times to the home of her parents. While the boy was in the grandmother's home he was neglected and rejected in favor of the mother's other son. At the time of the divorce the mother gained custody of this boy and his sister. For a time the two children were in a boarding school. After the father remarried, through legal procedure, he regained the children, who then came to live with him and the stepmother. Two sons have resulted from the second marriage. This boy was referred to the Mental Hygiene Clinic and through them to us because he was difficult to control, had temper tantrums, was sensitive and nervous, fought continually with his sister, was aggressive and annoying to other children, and showed little interest in school work. The child had received individual therapy from one of the psychiatric case workers almost continuously during the two years he has been in residence. For a period of eight months he was seen on a weekly basis by a child psychiatrist on the Center staff. The child's progress at the Center had been marked by "ups and downs." His school work improved but the two teachers with whom he has worked in the Center school reported his behavior as disturbing to the class and his academic progress less than was to be expected of a chlid of his intellectual potential (Altitude Q 124). On visits to his home the boy's behavior was still unacceptable to his parents although he seemed better able to accept criticism and correction.

In May 1955, thorazine treatment was started with this child, the dosage being 25 mg. q.i.d. orally. At the end of the first month of thorazine medication, his teacher noted continued improvement. The step-mother reported this boy as "exceptionally well-behaved" over a weekend. He was "quiet, pleasant, which is in marked contrast to previous behavior."

D.C., a girl of 13 came to the attention of the Family Court for violation of the curfew. Because of the girl's extreme resistance, the Mental Hygiene Clinic staff were unable to administer psychological or neurological tests to her. Although she was equally uncooperative in the psychiatric interview, she was observed to be withdrawn and was evaluated as a "decidedly disturbed youngster." When she was 4 years old, this child had been tested by the Mental Hygiene Clinic and found to be functioning at the "defective level in all spheres." Soon after her 11th birthday a school psychologist tested her and found her mentally retarded but working above her capacity in school subjects in her regular grade. During her 12th year she was in an individual progress class in a public school, which described her conduct as unsatisfactory, reporting her "contentious, pugnacious, and disagreeable." In this school, however, her academic material and handwork were rated "good". This child was born out of wedlock to a 16 year old girl who rejected her from birth. Her care had been the responsibility of her maternal grandmother from the beginning. When the girl was 5 the grandmother received legal custody of her. Since that time the mother maintained a common-law relationship from which resulted three other daughters, one of whom died in infancy.

D.C. is physically well-developed and well-nourished. From her grandmother's reports she seemed to have developed normally and to have been toilet-trained early and without unusual effort. She reached menarche at the age of 13 years, 5 months. The physical examination at the Center revealed a slight decrease in visual acuity in each eye. A severe hearing loss in the left ear was revealed by audiological and otological examination.

A psychologist at the Center found the girl surprisingly cooperative not long after she had resisted efforts to test her at the Mental Hygiene Clinic. In spite of her cooperation in the test situation and her apparent maximum effort, however, the test results indicated that she was functioning on a border line level of intelligence (I. Q. 70) with achievement in school subjects at about the low fourth-grade level. Projective data showed one outstanding theme: "Inadequacy, rejection, expectation of rejection or unhappi-

ness and anger, immobility and withdrawal . . ." The projective data also indicated some problems in the area of sexuality.

Because the girl was apparently so disturbed she was retained in the infirmary from the time of admission until nearly three months had elapsed. She was very unruly on the ward, defiant and challenging. She often hurt other children and called them foul names. She threatened to run away and several times did leave the building without permission but was returned by an attendant before she got very far away.

On one occasion she impulsively broke a window in the solarium. On being questioned she could not tell how or why she did this. Several times she was put in seclusion when she was particularly disturbed.

While this girl was in the Infirmary, she attended the classes held in the hospital building. For several weeks she did no classwork but reading. Her reading was on the 5th grade level. Frequently she did nothing but wander around the room. She was neither very obedient nor cooperative.

Once when she was quite upset and had been taking the clothes of the other children from a closet, claiming them as hers, she attempted to run away. On being returned to the ward she became so disturbed and aggressive that it was necessary to sedate her with neutral pack. The assistance of several persons was necessary to accomplish this. When she was removed from the pack, she was given Elixir of Phenobarbital immediately on being put to bed on the ward. The phenobarbital dosage was discontinued, and 25 mg. thorazine q.i.d. were ordered. The following day the nurse reported "quiet day." Five days later the same nurse wrote on the chart, "appears more cooperative since thorazine."

About one month later the ward nurse observed this girl as "very uncooperative this p.m. — using a great deal of foul language." She was put in isolation and 25 mg. thorazine were given orally. Early in the next month the thorazine dosage for this girl was increased to 50 mg. morning and night, 25 mg. at noon and afternoon. The nurses described her ward behavior as "fairly cooperative".

After being on thorazine medication intermittently for about two months, D.C. had improved to the extent that her removal to a cottage was possible.

In recognition of this girl's special need and severe problem with control she was not required to attend the regular school after she went to live in a cottage. She had expressed a desire to be allowed to "take care" of some of the patients. (Her grandmother had stated in the evaluation interview that the girl liked "to wait on people."). She was permitted to help the teacher who works with the epileptic children. This teacher reported that her "helper" is being "cooperative, willing to be of any assistance she can . . . Even though she does not have a 'regular schedule' here, she voluntarily does arithmetic, reading, etc." The teacher also observed that "during one of our children's severe seizures, she doesn't hesitate to ask if help is needed."

The occupational therapist noted a decided change in the girl's behavior. "She is almost always cheerful and often gives suggestions and help to others . . ."

The general report of the staff who evaluated the effect of thorazine medication on this girl was expressed thus: "There seems to be definite improvement. Sleeps a great deal. Is less erratic, responds better to environment. Has not displayed any psychotic behavior as she did before, but can still be irritable, obnoxious, and threatening at times."

CONCLUSION

While the use of chlorpromazine in children suffering severe emotional maladjustments is still too recent to permit definitive conclusions, nevertheless, certain compelling impressions of its value are evident. The experience of the staff at the Governor Bacon Health Center with this drug seems to indicate its effectiveness in the control of acting out children. Children receiving thorazine medication experience diminished aggressiveness and hostility and are more ap-

proachable. In many cases the children themselves acknowledge these feelings and appreciate their ability to control acting out impulses. A series of psychological tests are now in progress with the children at the Center who are being treated with thorazine. The results of this study will be reported later.

SUMMARY

1. Thorazine (Chlorpromazine) was used to control aggressive, destructive and hostile impulses in a group of 16 acting-out children.
2. The value of thorazine in controlling the overactivity and aggression of emotionally disturbed children is demonstrated in the small series reported here.
3. The children themselves are aware of their ability to exercise more adequate control of their acting-out impulses.
4. The effective dosage of thorazine in children is considerably higher than originally proposed. Daily rations of 3.5 mg. per kilo are well tolerated.
5. The incidence of untoward effects has been reassuringly low. Subjective reports of fatigue and "being tired" are not uncommon. Pseudo-parkinsonism occurred in one case receiving 20 mg. per kilo for five weeks. These symptoms were relieved by slight reduction of dosage and Cogentin.
6. With the diminished hostility effected by thorazine, the children related better to adults and peers. It may be useful, therefore, in accelerating warm and effective relationships with therapists.
7. In a group of 16 children, each of whom was a chaotic focus of aggressive and acting-out behavior, thorazine has enabled them to become more controlled, less anxious and defiant and better able to accept ambient limits.

ALCOHOLISM

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In order to have a better understanding of the psychoses that are due to alcohol, it is proper that we have a little understanding of this condition known as alcoholism. Alcoholism is a chronic progressive disease of unknown etiology or cause characterized by an abnormal response, uncontrollable drinking, to the ingestion of alcoholic beverages. Many theories as to causation have been advanced, but no single cause has yet been demonstrated. The abnormal response of alcoholics may take many behavior patterns and in the early stages of the disease produces one or more of a variety of symptoms. One of these is the blackout, better described as a temporary loss of memory without a loss of consciousness for variable periods while under the influence of alcohol. Another manifestation is the desire for a drink in the morning after having been intoxicated before retiring. Usually, there is a loss of appetite accompanied by aversion to food. The patient usually worries about his particular drinking habits which are marked by a feeling of uneasiness.

The disease is incurable in the sense that the alcoholic patient can never exhibit a normal response to alcohol. Alcoholism can be arrested, however, and recurrences prevented by divorcing the patient from alcoholic beverages for the rest of his natural life. Although there may be differences in relative incidents, alcoholism occurs in all racial and religious groups and in both sexes at any age. The therapy of alcoholism has been very indefinite and has varied with each worker in the field.

A review of the literature reveals a wide range of rationale in the handling of these patients. By large, therapy has been strictly medical or psychiatric. Medical treatment has been either by means of drugs or by replacement therapy. Drug therapy has largely employed the revoltive agents such as apomorphine and emetine which by conditioning produce in the patient an aversion to alcohol. The replacement methods have attempted to supply essential food substances and vitamins to restore the patient physically. Psychiatric methods have ranged from simple psychotherapeutic measures to highly complex, long, drawn out psychoanalysis. Variations in the therapy have depended upon the type of patient, that is, the psychotic,

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the feebleminded, the hobo and various levels of society.

A survey of therapy is available to the interested worker, that is, in-patient or out-patient. Availability of laboratory or research facilities, etc., and upon the attitude of the therapeutists to the problem.

It can not be accepted, however, that all alcoholics as a group are mentally ill. My impression is that the percentage of the mentally sick among these patients is no greater than it is in the general population. I believe that the average alcoholic can, with knowledge, guidance and determination, meet his problems as well as his fellowmen meet theirs. Any system of therapy must recognize the facts, that regardless of the method employed, a program must be outlined for the patient to enable him to maintain total abstinence. The system must be flexible enough to recognize that each patient is an individual who must be evaluated and advised on an individual basis that takes into consideration the total man. The system must encompass both medical and psychotherapeutic methods in its rationale.

The subject of the use and the effects of alcoholic liquors whether they are considered from a sociological, physiological or psychiatric point of view, still provokes much discussion and a wide divergence of opinion. We are here, however, concerned only with psychiatric aspects. Psychological knowledge and experience show that a practice so universal as that as the use of alcohol must exist because it satisfied some deeply seated psychological need. This need, it often appears, is for relief from the tension which has been induced by anxiety, frustration and conflicts. Anxiety is such a constant universal experience of mankind and alcohol is so effective in alleviating it that its use has become very wide. While the normal person has his anxieties, he is able to manage them without resorting to measures that tend to disturb his personality. His personality has grown to be well organized and his tolerance for anxiety, guilt and frustration is adequate. His need for relief from these factors is small.

In contrast, if the individual's tensions are extreme or his tolerance for anxiety and frustration is low, he may resort to excessive drinking, even to intoxication and this blotting out of reality as an easy means of relief and handling his difficulties. Any act that really results in a reduction of anxiety tends to become a habit. Although too frequently, therefore, the use of alcohol as a means of relief and escape becomes habitual. The strength of the habit depends upon the degree of anxiety which prompts it. At the same time also the alcoholic below the level of conscious awareness develops an obsessive nucleus of thoughts and feelings that drinking, and only drinking, will effectively quiet the maladjustments that make life uncomfortable or even unbearable. Alcohol serves, too, to create a vicious circle that aids in fixing the habit. Its use tends to release inhibitions. In turn, this threat of their release stimulates anxiety, for the relief of which more alcohol is required. Thus, alcohol is liable to defeat the ends for which it is taken.

Alcohol is a great deceiver. It produces the euphoric mood and a feeling of mental stimulation. Inhibitory factors are weakened. As a result, the patient expresses himself more freely and acts with more ease and less self-restraint. Because of the heightening of his sensory thresholds, the patient's sense of fatigue is diminished. As a matter of fact, alcohol has a depressing effect on all psychological functions yet measured. The relation between alcohol and the so-called alcoholic psychoses is not as simple as formerly assumed. In many incidences, alcohol serves merely to release a reaction that is primary psychogenic with factors intrinsic in the personality. In other cases there is such an interplay of psychogenic and metabolic factors that the picture becomes complex. In Korsakoff's syndrome and in chronic alcoholic deterioration, the psychosis is probably not as formally believed due to the toxic effect of the alcohol itself, but to vitamin B deficiency. Even in these structures of the personality influences, the picture one should remember, too, that alcoholism may be a symptom, some-

times the most obvious symptom of another psychosis such as paresis or manic depressive psychosis.

Let us consider first a condition known as pathological intoxication. Occasionally, a mentally unstable person may on partaking of even a small amount of alcohol suffer from a transitory mental state much more striking in the nature and severity of the symptoms than ordinary drunkenness, and it is known as pathological intoxication. The onset is dramatically sudden. This morbid condition is in effect a dream state suddenly produced by alcohol and is more prone to occur in persons of an epileptoid or hysterical temperament. Consciousness is impaired, and the patient is confused, disoriented, suffers from illusions, hallucinations of sight and transitory delusions. Activity is exaggerated, impulsive and aggressive even to the point of destructiveness. The emotional disturbances are profound and may consist of rage, anxiety or of depression perhaps with suicidal attempts. The disorder lasts from a few minutes to a day or more and is usually followed by a prolonged sleep, after awakening from which there is an amnesia for the entire episode.

The alcoholic needs not reformation but information. He needs the spiritual medicine of Alcoholics Anonymous as well as the physical medicine of the physician. These unfortunates are not inherently wicked. They are mostly of a cross section of our citizenry — often superior citizens. In many cases, their desperate stages, such as Delirium Tremens, reveal them to be suffering from a glandular deficiency — rapidly correctable by certain hormones which seems to overcome their excessive desire for alcohol. Dr. James J. Smith (Bellevue, New York) has been using large doses of A.C.E. (Adrenal Cortex Extract) in acute cases of DT's and his results are very gratifying. He based his treatment on the fact that the physical and mental signs of terminal alcoholism often resemble the fatal crisis of Addison's Disease — therefore, the use of A.C.E. Recently Thorazine has been used as an effective adjunct in therapy. It induces relaxation and sleep without stupor, controls vomiting and abolishes the anxiety and tension so often experienced by chronic alcoholics and it helps these patients to be more receptive to psychotherapy.

THORAZINE THERAPY

Difficulty in Predicting the Outcome

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and
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The usual indications for Thorazine are the symptomatic control of almost any kind of excitement, be it of organic or functional origin. The drug is extremely effective in reducing severe anxiety, modifying the course of acute paranoid psychosis, and changing acutely assaultive, destructive, hostile, agitated patients into quiet, calm, manageable individuals. At the present time we would like to report three cases in which the manifest symptoms were that of retardation, muteness, withdrawal, seclusiveness, negativism, and no evidence of any increased psychomotor activity. While we recognize that all symptoms are defenses against anxiety, and that basically there are very few conditions which do not have anxiety as the core of neurosis or psychosis, we are only reporting here on the manifest symptoms. However, we would like to point out here that we feel one of the chief actions of the drug is the dispelling of anxiety. With the dissipation of anxiety there is then no need for the defenses or symptoms which act as a bulwark against this anxiety and the conflictual ideational content. As a result of this change the overt manifestations of the clinical picture of the mental disorder is altered. The following are three case illustrations:

(1) M. S., 55 year old woman, was admitted to Delaware State Hospital on March 31, 1955 with a diagnosis of schizophrenic reaction, schizo-affective type. This was her fourth attack. On this admission the patient was withdrawn, negativistic, would not respond to any questioning, and would not accept any food. She seemed listless and stuporous. On April 16, 1955 she started on Thorazine,

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200 mgms., I.M., daily. Because she remained seclusive, untidy, and still negativistic, the drug was increased to 400 mgms. I.M. daily. Four days after the initiation of the drug she became more alert, pleasant, and began to eat. The patient began to take a personal interest in herself. She talked about her problems freely and stated that she had been actively hallucinated. Because of the tremendous improvement she was changed from Thorazine I.M. to Thorazine P.O. The drug was discontinued on May 26, 1955 at which time the patient was friendly, co-operative, and receptive to psycho-therapy. She was completely free of psychotic symptoms and had gained some insight into her problems. The patient was therefore placed on trial visit on June 23, 1955.

(2) A. G., 41 year old female, was admitted to the Delaware State Hospital June 11, 1955 with a diagnosis of a paranoid reaction, paranoid state. Three weeks prior to admission she stated she had heard voices calling her derogatory names. She stopped working and became completely withdrawn. The patient remained in her room and began to think that people were watching her. It was at this point she felt she needed protection from these "people", and as a result admitted herself to this hospital. On admission she was withdrawn, preoccupied, seclusive, appeared to be actively hallucinating, blocked, and uncommunicative. On June 12, 1955 she started on Thorazine Therapy, receiving 200 mgms., I.M., daily. While in the hospital the picture altered. In addition to being withdrawn, preoccupied, and hallucinated, she was extremely depressed and guilt-ridden. On June 18th, six days after the administration of the drug, she appeared less depressed, began to socialize, and became quite active on the ward. She then began to talk about some of her emotional difficulties rather readily, and was able to gain some reassurance from the interviews. At the present time she is still in the hospital, completely free of any psychotic symptoms and seems to be better intergrated. She is in good spirits and is optimistic about the future.

(3) A. B., 56 year old married woman was admitted to Delaware State Hospital, January 21, 1955 diagnosed: involutional psychotic reaction. On admission patient was extremely depressed, withdrawn, had numerous somatic complaints and nihilistic ideas. She seemed blocked and negativistic. The patient held her body in an erect, rigid fashion and at times appeared to be motionless. She was given two courses of electro-convulsive therapy only to relapse to her previous withdrawn, negativistic state. On May 24, 1955 Thorazine 200 mgms., I.M., daily, was started. After being on the drug for seven days she became more communicative, socialized, friendly, and worked around the ward. She became more spontaneous. There was no evidence of the psychotic symptoms that were previously described. Because of this tremendous improvement she was taken off the drug June 9, 1955. She remained friendly, active on the ward, cheerful, optimistic, and amenable to psycho-therapy. The patient was discharged on July 18, 1955.

We recognized that these three case illustrations are not conclusive. However, we feel that, in view of the results of the drug therapy in these three patients, there is no rule for determining and predicting the outcome of Thorazine therapy by manifest symptoms alone.

THORAZINE (CHLORPROMAZINE) AND SERPASIL THERAPY

In Hyperactive Patient of Low Mentality

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The patient referred to in this case is a white male, born November 13, 1943. At the age of two he began to show a hyperactive pattern with such behavior as pushing and pulling on the other children, rolling on the floor and totally devoid of any toilet training and not receptive to any. Irregularity of habits such as daytime sleeping and nighttime hyperactivity. Also, a gross feeding problem. As he grew older the pattern of behavior became more intensified and at the age of five it was totally impossible for the family to manage him. He was admitted to the Del-

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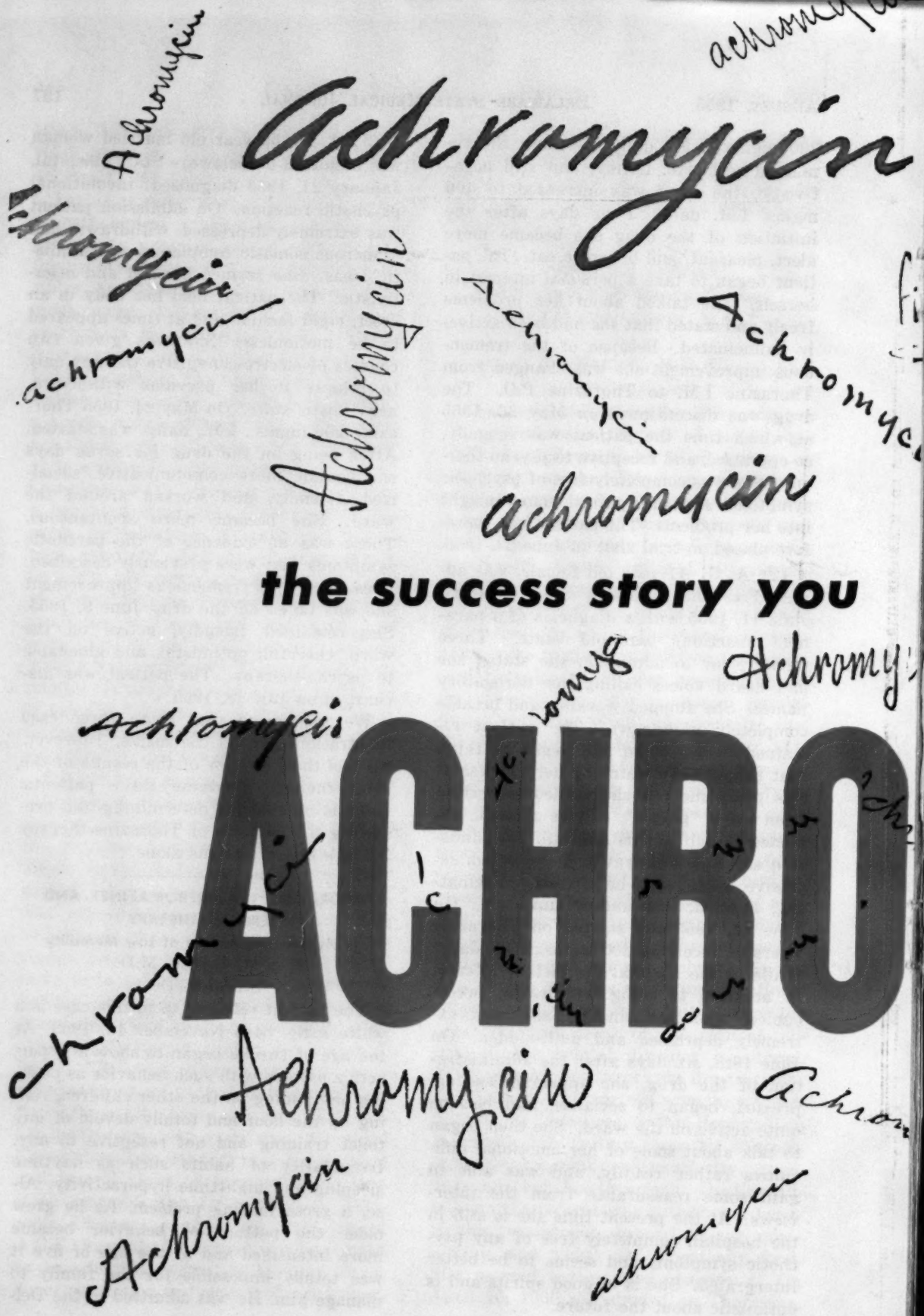
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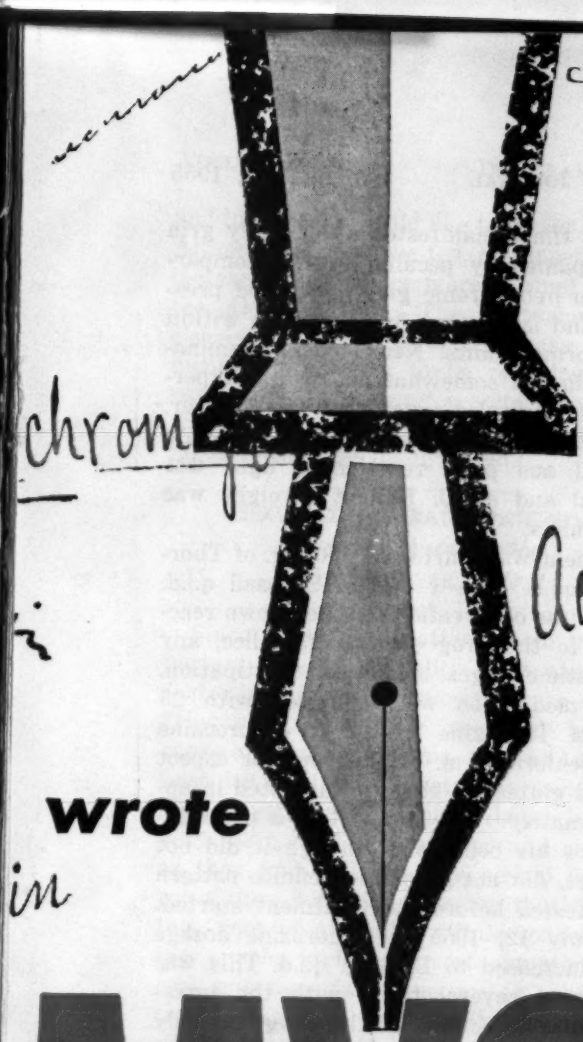

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aware Colony on November 11, 1947.

Upon admission to the Colony his behavior was studied and the following was reported. He was extremely hyperactive, very destructive with clothing, toys, or anything that he could grasp. He showed a gross pattern of autocombativeness such as beating his forehead upon anything in sight. When extraneous objects were not available he beat his forehead with his fist. He developed large hematomas about the frontal and temporal regions. When exhausted from this behavior he lies and screams as if in a temper tantrum until he regains his strength and the beating continues. Sedation appeared to have no effect. He required the maximum of nursing and attendant care and at times required three or four attendants to restrain him from injuring himself or others. After a year at the Colony he developed new factors in his behavior such as bird-like whistles, smearing and manifesting a coprophagic pattern. He also lost weight as he was a severe feeding problem.

This psychopathologic framework of weird and bizarre behavior continued gathering momentum until it was felt that the possibility of a prefrontal leucotomy might be indicated to alleviate this condition. His medical record read like a pharmaceutical catalog of sedation, but nothing appeared to improve the situation. His physical condition began to show the ravages of this psychiatric behavior.

On July 11, 1955, a program of Thorazine and Serpasil medication was inaugurated and this patient was the first on the list for treatment. Physical examination on that date disclosed a grossly hyperactive twelve year old white male very noisy, manifesting squealing, whistling and cackling noises. Gross examination revealed an impressionable microcephalic. His forehead showed fresh contusions with a large organized mass in the center from previous trauma inflicted upon himself during his head-banging episodes. He was making every endeavor to smear accompanied with a coprophagic pattern. There was a marked contusion of the right eye and many areas on the lower extremity. When spoken to he was not responsive but at times manifested a very silly grin accompanied by peculiar sounds comparable to hebephrenic giggling. Blood pressure and laboratory findings were within the normal limits. Neurological examination, limited somewhat due to his hyperactivity, revealed equal sided motorpower. Reflexes, physiological. Ocular movements normal and pupil reaction to light was normal and equal. Patient's weight was 38 pounds.

Patient was started on 100 mg. of Thorazine q.i.d. with 1 mg. of Serpasil q.i.d. with close observation for the known reactions to the drug such as jaundice, any dermatic changes, tremor, or constipation. This medication was enhanced with 25 mg. of Thorazine with 2 cc of procaine hydrochloride i.m. at the superior aspect of the gluteal. A change was noted in approximately four hours. The demonstration of his behavior, although it did not change, did not show the definite pattern manifested before the treatment started. On July 12, 1955 the Thorazine dosage was increased to 150 mg. q.i.d. This was enhanced several times with the intramuscular injections of the drug. On July 18, 1955 this patient had responded very well with this program of treatment. He was totally out of restraint, demonstrating no smearing or coprophagyic pattern, a total absence of head banging, and was walking about the grounds adjacent to the infirmary under the supervision of an attendant. On July 19, 1955 his medication was cut back to 50 mg. of Thorazine q.i.d. due to a somewhat lethargic pattern, not alarming in nature, which disappeared very shortly. He was examined that date by the superintendent and was placed on the ward with children comparable to his level and age and has up to the present date responded very well and still shows signs of improvement. No side effects were manifested from the drugs up to this writing.

The most dramatic factors in this case are; a total relief from restraint, a total absence of smearing and coprophagy, no head banging, a response when his name is called, and a friendly almost recognizing attitude. He will now take your hand

and indicate he would like to go for a walk. Although he must be fed, his appetite has increased and he is more normal in his reception to food. The contusions are clearing and the organized mass above-mentioned appears to be reducing. This patient is approaching a point whereby a training program appropriate to his mental level may be inaugurated.

SEXUALLY FRUSTRATED PATIENTS

A Common Misconception

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Since Freud drew attention to the important role of sexuality as a causation factor in nervous and mental illness, sexual frustration has been accepted as the cause of many symptoms, such as anxiety, hostility, irritability, disturbances of sleep and appetite. Physicians have become very alert to this possibility and as soon as they find difficulties in sexual adjustment they will often assume that this is the "root of all evil". While concentrating on the striking, overt symptomatology, one may fail sometime to recognize that in many cases sexuality is only one of the disturbed functions in a more profoundly disorganized personality. In our present time, medicine is unfortunately ruled to a certain extent by stereotyped associations, like heart failure—digitalis or infection—penicillin, and the association neurotic symptom—sexual disturbance seems to become integrated into medical knowledge in the same way. The finding of disturbed sexuality will lead to therapeutic advice. Marriage will be recommended, or a friendship. The patient's mind has already been prepared for this by the numerous 'popular' psychological publications along this line. Even though direct action may not be the result of this advice, it is probable that it will strongly influence the thinking of the patient, in many cases to such an extent that marriage will be taken as a way out of a more serious emotional problem.

Unfortunately a person in nervous distress is in no position to choose a partner for life and will most likely make a neurotic choice, or else two people will be attracted to each other through their mutual understanding and acceptance of neurotic problems. The result may be the union of two partners who were barely able to cope with life individually, and soon find themselves in even deeper difficulties in their attempt to master life together.

The following histories of cases I saw in recent years, prior to coming to this country, may be given as examples.

A. D., a 24 year old married woman, had been shy and nervous all her life. She had feelings of inferiority and worried excessively that her work would not be acceptable, first at school and later in the office where she worked as a clerk. The patient had difficulty in establishing satisfactory relations with the opposite sex, and this led to some preoccupation. There was also considerable trouble with her menstruation. She felt sick and nauseated, vomited, had sharp pains and had to miss work two or three days each month. The family physician recommended sexual intercourse and marriage. Consequently, at the age of 21 she became involved with a young man who was her opposite in personality traits: easy going, rather conceited about his abilities and his success in life. She became pregnant and they had to get married, although the patient had misgivings from the beginning about the wisdom of such a marriage. The birth of two children followed at short intervals. The physician had been correct in predicting the disappearance of her menstrual problems. However, the loud and superficial attitude of her husband increased her psychological difficulties to such an extent that she had severe anxiety attacks, could not breathe normally, and was unable to cope with her duties as housewife and mother. She felt overwhelmed by the responsibility of caring for the two children, and developed vaginism as a defense against the irresponsible sexual habits of her husband which she was afraid would lead to another pregnancy.

G. E., 34, an unmarried business woman, had been brought up in a very wealthy home and had had an excellent

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education. She was of extroverted and friendly personality and had been popular at college. However, her overly strict upbringing resulted in a rather reluctant and defensive attitude toward the other sex. This was increased by the fear that masculine attention was given her mainly because of her money. She consulted a psychiatrist during her college years about difficulty in concentrating on her studies and her stage and examination fright. The doctor attributed this to a lack of sexual gratification. She followed his advice and started an affair with a co-student. This young man took advantage of her financially several times, and because of his own maladjustment was quite unable to give real affection. Although she continued to be attracted to him she broke off the affair eventually for rational reasons and upon the insistence of her family. When I examined her two years later she had a severe obsessive-compulsive neurosis, her thoughts circling around sex, with a washing compulsion and fear of germs to an almost delusional degree. In therapy these symptoms could be traced back to episodes in the love affair, which she had experienced as something extremely distasteful because of the material interests of her partner. She had never subsequently been free for another friendship or sex relationship, due to excessive suspicion that her failure would be repeated.

G. L., a 26 year old man of Italian descent, had been brought up in England in an extremely puritan home. He had always been a shy, retiring, anxious person who showed a need to be accepted by his environment. During his term in the Canadian army in the last war he consulted the army physician about his nervous condition, consisting of insomnia, difficulty in concentration, loss of appetite and weight, nausea and vomiting, all of which were interfering with his performance of military duties. He attributed his symptoms to the vulgar language and loud behavior of the other men, and to their uninhibited attitude toward their sexual adventures. He became very seclusive and lost all contact with his colleagues, describing them as "a pack of animals". The physician advised him to adopt a more lenient attitude, to join his fellow soldiers on their next leave from camp and to find himself a girl in the neighboring town. This experience, far from having the intended beneficial effect, was followed by a marked deterioration. He became so depressed and blocked in all his mental function that he was admitted to a mental hospital. Though recovered from this reactive depression within six months, he required intermittent psychiatric treatment for many years.

These case histories have in common the situation of a physician or psychiatrist advising the patient to seek sexual gratification. The advice is followed and leads to hurried unsuitable relationships. Proper initial treatment may have shortened or obviated the necessity for later extensive therapy.

The general trend leading to this type of situation is partially due to modern views of normal sexual behavior. About 50 years ago less attention was paid to the unmarried person in the spinster or bachelor category. In our time of knowledge and sophistication in the sexual field, these people seem frequently to be labelled with superficial psycho-pathological terms by a more or less educated environment. This extends so far as to declaring them abnormal. The very complicated psycho-physiological structure of human beings does not permit over-simplification and it is dangerous to use such mental short-circuits.

Two of the cases cited above were handled by general practitioners and one by a psychiatrist. It is difficult to evaluate the most competent person to give advice on the subject of marriage and sexual behavior. The family physician is probably better acquainted with the background, while the psychiatrist has a more detailed knowledge of the deeper psychology and the present condition. Both should exercise caution when extensive treatment is not feasible. Often simple reassurance and allowing the patient to find his own way is the best policy.

The frequent disappearance of menstrual difficulties after marriage or establishment of regular sexual relations should be mentioned. Again, there is some danger in giving definite advice, and the complexity of factors involved should not be underestimated. One should also realize that the severity of menstrual pain may be subjectively exaggerated, and in itself may be almost entirely of neurotic origin. Therefore, even casual remarks concerning the relief of such symptoms after marriage or childbearing should be avoided since they may be taken more literally than intended.

The question of normal sexual adjustment has been of considerable interest and has led to many discussions, especially since the publication of the Kinsey Report. A comprehensive discussion cannot be included here. Kinsey[1] refers to the many approaches to the problem in the statement: "Wherever one finds contradictory interpretations of what is sexually normal and abnormal, one should consider whether philosophic, moral, or social evaluations, or scientific records of material fact are involved".

For the physician the scientific investigation of fact should be the first source of information. However, other factors must be considered because of their influence on the psychological condition of the patient. Bychowski[2] stresses this fact by stating: "Clinical experience demonstrates that human sexual behavior is largely psychosexual, that is, psychologically patterned. It is for this reason that any behavioristic investigation of sexual activity, as isolated from the consideration of a total personality, must fall short of its ideal of scientific completeness and objectivity". The ideal of complete knowledge and understanding of the patient can be achieved only in a few cases. Even in analytic therapy one sees merely the present condition of the patient. A few years, or even months, later, he may have a different attitude to his problem than during the time of therapy, and under the influence of the transference.

Very often the patient may ask direct questions on the subject that have to be answered. This should never be done in a general way, but the individual facts of the case should be considered. It is necessary to present the patient with all the pertinent facts related to his sexual problem in an objective and non-directive fashion, so that he will gain true insight into his situation. Thus he will be in a position to formulate a stable solution that will be valid during future development. Short of a comprehensive dealing with the individual case, it is a wise alternative to allow the patient to find his own way during the maturation of his personality.

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THORAZINE IN SURGICAL-PSYCHIATRIC EMERGENCIES

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The following is a report of two cases which have shown beneficial effect on Thorazine treatment. One is a chronic case and the other is an acute case.

The first patient is 19 years old and is at present hospitalized here. He has been diagnosed as schizophrenia, juvenile type. He was admitted here on regular commitment papers in December, 1947. His developmental history indicated abnormalities of behavior from the very beginning. Before his hospitalization here he had been at two private schools for emotionally disturbed children. He never attended public school.

His history is characterized by a very early onset of over-active, destructive, and unpredictable behavior. He is an only child. He has shown ability along mathematical lines. Although exceedingly intelligent in some aspects, he never had the ability to concentrate for any length of time and consequently failed to make any scholastic adjustment. Since his admission here he has shown temper tantrums and uncontrolled behavior. He has been extremely compulsive and disturbed at intervals. He has had electro-shock and in-

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sulin-coma treatments here. Later he had four convulsive treatments at the University of Pennsylvania Hospital, Philadelphia, induced by oxygen inhalation in the pressure chamber. He did not respond to any of the various treatment procedures. He continued to be a difficult management problem in the hospital.

He also had auditory hallucinations. He complained of voices tormenting him. The episodes of disturbed behavior continued, such as breaking windows, etc. Because of his recalcitrance and lack of significant changes to the above-mentioned treatments he had a transorbital leucotomy performed in April, 1951. Following this operation he had fewer auditory hallucinations. The improvement, however, was not maintained and patient was again given two electro-shock treatments. Hydrotherapy was also of no avail.

He had a second transorbitol leucotomy performed in April, 1952. He showed less motor activity for several months after the second operation and adjusted better on the ward. In July, 1952, however, he again required electro-shock treatments.

On March 31, 1954, he was started on Thorazine treatment for his overactivity, restlessness, destructiveness, and assaultiveness. In the beginning he was given 50 mgms. of Thorazine intramuscularly, q.i.d. Later the dosage was increased to 100 mgms. orally, four times daily.

His first course of Thorazine treatment lasted for 86 days. During this period he received varied doses of Thorazine, reaching a maximum of 200 mgms., orally, q.i.d. His hyperactivity was reduced and he rested better. He was more cooperative while receiving the Thorazine.

After several months, he reverted to his previous behavior, however, so that it was necessary to re-start Thorazine. The second course consisted of 81 days of treatment. The evaluation, at the conclusion of the second course, indicated that the patient had shown improvement to the extent that he was working on the grounds under supervision whereas he had been destructive and assaultive and frequently had to be secluded before treatment. He was quiet and cooperative after the Thorazine treatment. It was possible to permit him to go home for the Christmas holidays. His family reported that he did very well during his visit home. He escaped from the hospital in June, 1955 and received a severe fracture of the right femur and a compound fracture of the right humerus. He required intravenous fluids and a blood transfusion. It was again necessary to re-institute Thorazine treatment, as patient became extremely disturbed to the extent that he removed the splint that had been applied for the fracture of the right femur. He was then given Thorazine 250 mgms., intramuscularly every six hours, after having been started on smaller dosages. There was a marked quietening effect on the patient. After he had shown sufficient inhibition of his psychomotor activity he was placed on Thorazine, 250 mgms. orally, every six hours, with continuation of his improved behavior.

He has had surgical intervention for the fractures. At present, he is alert and cooperative. It has been possible to discontinue Thorazine as long as his present behavior is maintained.

The second case is that of a 39 year old, white, male patient. He was an acute postoperative case, in a general hospital. He had had a herniorrhaphy. The history revealed that he had a scar of the right femur from a previous osteomyelitis. Eight days after his herniorrhaphy he had an incision and drainage of the right femur for osteomyelitis. Acute psychotic symptoms followed the latter operation which necessitated transfer to the Delaware State Hospital. At the time of his admission here, which was four days after the latter operation, he was completely inaccessible. His temperature was 103° axillary, pulse 140, respirations 18, and blood pressure was 148/88. He was perspiring profusely.

He became quite tense and restless. He was unresponsive verbally and took no nourishment by mouth. He received duracillin and intravenous fluids. Because of the restlessness and agitation Thorazine treatment was used symptomatically.

The hyperactivity was reduced. He became quieter and was able to sleep. There was no change in his reality awareness. After orthopedic consultation the patient was transferred to the general hospital for further treatment of the osteomyelitis.

These two cases demonstrate the effectiveness of Thorazine in controlling acute or chronic psychiatric states. Both cases were complicated by acute surgical conditions which could not be managed before the psychotic behavior had been controlled by Thorazine.

"AFFLUENCE THERAPY"

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What is "affluence therapy?" Is this another term to join the already confusing dilemna of diagnostic and therapeutic syllabary? This is certainly not the intention of the writer, but rather, to delineate certain aspects found therapeutically beneficial during the course of treatment of the chronically ill mental patients. Before we get involved in medical and psychiatric lore, let us get the ordinary meaning of the word "affluence." Affluence is defined as . . . "abundant supply flowing toward a certain direction . . ." The supply indicated may be tangible or intangible. In our particular instance, we indicate the beneficial effect derived from treatment procedures causing indirect influence to patients not actually receiving active treatment.

In a study of chronically ill mental patients at the Delaware State Hospital observations noted improvement in patients, physically and mentally, who otherwise were not directly treated with drugs or psychotherapy. During a series of treatment procedures instituted in the chronic wards, the change in the tempo of routine activity created a corresponding change in the atmosphere of the entire ward. This was brought about by a reaction from otherwise untreated patients disseminating the beneficial effects. Drug therapy using Thorazine and Serpasil, psychotherapy sessions, group as well as individual, were actively going on at the time which served as the nucleus or spark of ward activity. Untreated patients who did not have any part in the treatment procedures reacted, nevertheless, by sympathetic vibration, as it were, reflecting response as in a mirror-like phenomenon. Therefore, patients showed improvement as the others moved under active treatment. They manifested varying degrees of concern, anxiety, interest and activity which made way for some adjustment as they opened up and reacted to the environment. The significance of the reaction is that it is purely voluntary and independent from reactions of the other patients showing individual responses independent of therapist and therapy. This fact also accounts for the longer and more lasting effect of affluence therapy.

As the affluence spreads out, there is diminishing effect upon the remaining patients in the same ward which could be visualized as being in the periphery of the dynamic circumference. The action of affluence therapy, therefore, is centrifugal. Like in a ripple, there is a widening circle of effect dissipating toward the periphery. This is easily discernible as attention, ability, interest and capacity are lessened in these remaining patients. There is also diminishing strength and force of effect as radiating affluence extends to the periphery of the ward.

Affluence therapy should be differentiated from another recently introduced but long familiar psychology of millieu therapy. This is important because both of them involve environmental changes but their respective action is different. Millieu therapy as used in other studies by other writers denotes the environmental modification to more appropriately adapt outside factors surrounding patients to their mental condition. The action is, therefore, centripetal emanating from the peripheral environment as a beneficial change directed toward and affecting patients at center of operation. As we have explained, affluence therapy acts in the opposite direction which is centrifugal with the change emanating from the center of activity radiating toward and affecting the peripheral environment.

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Another subtle point to emphasize is to differentiate "affluence" from "morale". Affluence, in our particular use of the term, and, morale both refer to a state of mind. However, affluence connotes movement of this state of mind which is the important therapeutic effect we would like to bring out. This movement may, of course, be beneficial or not, but study of 220 chronic patients over a period of 6 months showed more beneficial effects than not. At any rate, there is definitely reaction characteristic of individual cases which could be utilized, channelized or what-have-you in finding a workable focus toward better adjustment if not actual productivity. The dynamics involved in affluence makes for a longer and more lasting effect which further differentiates it from morale which is only of the moment or brief period of time. This makes affluence a big factor to develop and incorporate in treatment processes whatever they be. As adjunct to the bedside manner, the therapist who ignites the spark produces a more extensive treatment program covering a larger number of patients than he would ordinarily realize. The effects and possibilities of affluence therapy give unlimited promise and an interesting field to explore.

GROUP PSYCHOTHERAPY
As A Form of Rehabilitation Service

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Claymont, Del.

Soon after the opening of the Mental Hygiene Clinic in 1929, a consulting service for the residential training schools dealing with delinquent youngsters was established. It has been customary among the social workers of these institutions to refer practically all their inhabitants to M.H.C. for evaluation. Although follow-up studies are not available, recommendations made by M.H.C. examiners have often helped the school administrators in planning the most suitable program for a given youngster, and probably therefore in speeding up his (or her) rehabilitation. Another form of service, individual psychotherapy, has been given on a limited scale only, mainly because of the staff shortage.

Group living itself has a therapeutic effect on some anti-social individuals; others derive little benefit from it, exploiting those in charge of them and adversely influencing their fellow inmates. Organized discussion groups with a therapeutic aim in mind have often been found to be valuable in institutional settings. The literature on group psychotherapy of the past fifteen years is overwhelming, including both informal reports as well as systematic experiments.

Two staff members of the M.H.C. had conducted therapy groups with the youngsters of the three Delaware training schools prior to the present project. Because of their apparent success, and since one of the present writers has had previous experience in group psychotherapy with institutionalized offenders, we started in October 1954 with a selected group of ten girls from one of the Girls' Industrial Schools. The following account is intended to point out the usefulness as well as the limitations of group psychotherapy if conducted by a person who is not a member of the resident staff.

Institutionalized individuals of all ages have in common an excessive demand for attention, which of course originates from their forceful removal from their families and the impersonal atmosphere of life among strangers. The establishment of consistent, meaningful, positive relationships is generally agreed to be the most forceful factor in social rehabilitation. In group therapy sessions, the accepting, attentive, non-punishing adult is only one of the therapeutic agents; the peers, whether they be hostile or approving, are of at least equal importance. "Gripes", unfulfilled hopes, frustrations, daydreams, etc. can be expressed in any manner, vociferously or cautiously, according to temperament. The relationships among the youngsters, their tendencies to either lead others or to be followers can be studied and constructively channelled. Their social values, whether they be gen-

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** Superintendent, Woods Haven School for Girls.

erally acceptable or only characteristic of their own sub-culture, form the subject of serious, lengthy, sometimes heated discussions. Occasionally, anti-social sentiments may be expressed in an exalted fashion by the majority of the group members, to be discredited and discarded after thorough scrutiny of the issue. Emotional growth is enhanced when the all-important peers disavow certain unwholesome attitudes (e.g., in the area of sex conduct).

The initial group was selected jointly by M.H.C. and the School administration. The criteria for selection were: at least a few months of residence at the School and more than average difficulty in adjusting to the institutional routine. Six of the ten girls had run away previously. The group has been conducted since on a continuous basis with various changes in membership. Keeping in mind a desirable maximum number of ten, the girls are encouraged to invite others, whenever through release, job placement, or escape, vacancies occur. In one instance, a girl withdrew from the group without any of the above reasons. A 13 year old was excluded by general consent; being both too dull and too immature for this particular group. The present group (July 1955), except for one girl, consists of an entirely new population as compared with the initial one of nine months ago.

A few simple figures may illustrate to what extent, quantitatively, the project has been a part of the total institutional program:

New Commitments 1953-'55 48
Participants in continuous group since October 1954 18 (37.5%)
Or, stated differently:
Daily average number of girls in residence during fiscal year 1954-'55 27.4
Average size of the therapy group 7.5 (27.4%)

Thus, from one-fourth to one-third of the W.H.S. population has been participating in our project.

The clinical psychologist meets with the girls once a week for one and one-half hours. Sessions have been held a few times on the institutional grounds, but mostly at the M.H.C. The girls not only prefer the latter because of the pleasure of riding, but sessions turn out to be more productive since the temporary removal from the daily milieu tends to liberalize the expression of one's pent-up feelings. The group therapist also had one session with the entire staff of the School in order to interpret the procedure to them. This session hopefully has alleviated the apprehension among some of them concerning the permissiveness of expression which group therapy entails.

Two techniques and a combination of the two have been utilized: Straight discussion (in which the group leader remains in the background as much as he can), and role playing. Discussion topics (selected entirely by the group members themselves) run the gamut of interests of adolescent girls, whether they live in a restricted environment or not: marriage, boys, grooming, clothing, entertainments, school, careers, etc.; in addition, of course: the hope for early release, escaping, illegitimate conception, institutional staff, police, etc. Dramatization (also selected by the girls) included such scenes as: being at a hearing before the Family Court judge; ganging up on a newly admitted girl by asking her indiscrete questions; applying for a job; being "picked up" by a boy; having a date during home visit; cottage meeting at the School, etc. Interests vary from session to session. Sometimes they would be more specific, the group concentrating on the characteristics of a certain person, be it a peer or somebody in authority. On some occasions, an attempt is made to arrive at general principles. Various sorts of group tensions are brought into the open, not only the perennial social gap between "inmates" and staff, but also such clashes as "up-state" versus "down-state" girls. One joint session with the Negro girls from the Kruse School which had been desired by both groups for a long time, was quite successful. On that occasion girls compared notes on institutional regulations, and some old public school friendships were revived; a gen-

** Superintendent, Woods Haven School for Girls.

eral spirit of comraderie prevailed on that occasion.

In supplementing a time-honored institutional program with a comparatively novel procedure, the first questions arising are: "Has it done any good? Has anything been accomplished that could not have been accomplished otherwise?"

A research approach to answering these questions is extremely difficult. It would necessitate the establishment of a "matched control group", i.e. an equal number of individuals with similar characteristics as those under study, who are not exposed to group therapy. Furthermore, a follow-up period for both groups of at least five years would be required to clarify the above questions.

The present report can make neither of these claims. Instead, we shall follow one of the girls through her institutional placement, and parallel this with her development during group sessions.

THE CASE OF SALLY W.

Prior to Commitment. The attractive high school junior was referred to the school psychologist in January, 1954 because of constant tardiness and because mother had lost control over her. Even two months previously her mother had filed a complaint in court, but had withdrawn it again. Sally was found to be of average intelligence, but quite immature and self-centered. When the girl was found by police late at night in the car of an adult man her mother signed a warrant for her. Family Court committed her to the School on June 24, 1954. She was 16½ years at that time. In the M.H.C. examination, she was talkative and flippant; expressed tremendous hostility against her overbearing mother; glorified one of her adult boy-friends as a "gentleman"; the individual that she would like her father to be. She expressed some vague idea that one day she might become a secretary, but seemed more concerned with early marriage.

At the School. Sally was quite disturbed at the time she was committed because of her emotional attachment for the boy with whom she was involved, and her interest in a second boy. In June she escaped and was returned the same day. From that time on Sally settled down quite steadily. She attended Claymont Public School in fall, entering once more the 11th grade. However, she did not concentrate on her work, had poor marks, was not always a dependable citizen. With the help of the guidance director of the public school it was possible to carry her along in her school work until winter when she continued to have very poor grades and became so uncooperative that the privilege of attending school was removed. It was suggested that she obtain training in housekeeping instead. She had received an engagement ring and was looking forward to being married when paroled from the school. The young man in whom she was interested was investigated (not the one involved with her in delinquency), and since he seemed to be quite stable, this relationship was encouraged. At first she was able to do only a few things in the kitchen: was poorly organized and irresponsible about her approach to planning a meal, getting it ready, and in her care of the kitchen. She improved in all these areas. Was paroled June 16, 1955 to her parents in order to marry her boy friend less than three weeks later. She and her husband have visited the school once and stated that they are very happy together.

In Group Therapy. Participated in 31 sessions. During the first few talked little, did not feel accepted by others. (3) Wants to be married after release, but was not sure to whom; was suspicious of other girls' feelings toward her, "everybody gives me a dirty look". (4) Was ridiculed by others for calling every staff member "mommy". Was unable to defend herself. (7) Expressed negative feelings concerning her detention at W.H.S., and distrusted staff: "I call it a junior workhouse!". (9) During a lively discussion of wedding nights, brought up the question of her own shyness and wondered whether this would not affect marital happiness. (10) After dramatization of a night club situation in which a young man picks up a rather uninhibited girl,

(continued on page 199)

Editorials

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MERGER OF THREE INSTITUTIONS FINALLY ACCOMPLISHED

At the annual meeting of the Medical Society of Delaware in 1952 the report of the Committee on Mental Deficiency was unanimously approved and the Society passed appropriate resolutions to "make this report a living blue print for future planning for the intra and extra mural care, treatment, training and education of mentally defective and retarded children and adults in our state".

This report was approved in principle by various national organizations. Among other recommendations the report states: "It is the opinion of the Committee that the Delaware Colony for the Feebleminded is one of the segments of the Mental Health Department which should be composed of the Delaware State Hospital at Farnhurst, the Governor Bacon Health Center at Delaware City, the Welfare Home at Smyrna, and the Delaware Colony for the Feebleminded at Stockley. The above four institutions should be under the jurisdiction of one Board".

The 118th General Assembly passed, and on June 30, 1955 the Governor signed Senate Bill No. 419, an act which in Section 1 states: "The Delaware Commission for the Feebleminded is abolished and all the persons under its care shall be under the care of the State Board of Trustees of the Delaware State Hospital."

In Section 2, Paragraph 5501 states: "The Delaware Colony for the Feebleminded at Stockley shall continue to be the State facility for the treatment and maintenance of the feeble minded."

Paragraph 5502, Control and Management of the Colony, states: "(a) The State Board of Trustees of the Delaware State Hospital at Farnhurst shall have sole and complete control and management of the Delaware Colony for the Feebleminded at Stockley.

"(b) The Board shall appoint an assistant superintendent of the Colony, physicians, specialists, nurses, stewards, matron, educators, and all other necessary assistants and employees, and shall fix their term of service as well as their pay or compensation.

"(c) The Board shall provide suitable food, raiment, medicine, occupational, vocational, recreational and educational facilities, and all other things necessary for the comfort, care and treatment of the patients of the Colony.

"(d) The assistant superintendent of the Colony, and all other professional assistants and employees, shall be directly responsible to the Superintendent of the Delaware State Hospital at Farnhurst, who shall also be the Superintendent of the Colony."

At the same time the General Assembly passed House Bill No. 154 with House Amendment No. 1 "Appropriating to the Delaware Colony for the Feebleminded

$925,000.00 from a Bond Issue to build and equip an infirmary".

Also passed was House Bill No. 157 "Appropriating to the Delaware Colony for the Feebleminded $15,000.00 each year of the coming biennium for the care of abnormal children under 6 years of age, to be placed in other Institutions while waiting admission to the Delaware Colony for the Feebleminded at Stockley."

Also passed was House Bill 158 with House Amendment No. 1, "Appropriating to the Delaware Colony for the Feebleminded $67,536.70 from a Bond Issue to convert present Kitchens in the Delaware Colony for the Feebleminded at Stockley into Service Pantries".

Also passed was House Bill No. 406 "Appropriating to the Delaware Colony for the Feebleminded $6,500.00 for the purchase and installation of a Fire Alarm System at the Delaware Colony for the Feebleminded at Stockley".

Also passed was House Bill 156 with House Amendment No. 1, "Appropriating to the Delaware Colony for the Feebleminded $37,000.00 from a Bond Issue to equip the new Central Kitchen at the Delaware Colony for the Feebleminded at Stockley".

We congratulate the Governor and the General Assembly on their decision to amalgamate the Delaware Colony at Stockley with the Delaware State Hospital and the Governor Bacon Health Center. This consolidation of three important mental health agencies will create better care and treatment for the mentally ill and the mentally retarded and there will be better coordination among all three institutions under one jurisdiction.

We also congratulate the State Board of Trustees of the Delaware State Hospital and Doctor Tarumianz for their willingness to accept the additional responsibility. We wish them success and can assure them that every member of the medical profession in Delaware will be willing to assist them in their endeavor.

MENTAL HEALTH TRAINING AND RESEARCH BILL

We are delighted to report that House Substitute No. 1 for House Bill No. 300, "An Act to Establish a Board on Mental Health Training and Research and Making an Appropriation Thereto", was passed by both houses of the General Assembly and signed by the Governor. The bill reads as follows:

"WHEREAS, the Governor's Committee on Mental Health Training and Research has carefully studied the problem of mental illness and mental deficiency, and

"WHEREAS, the care of the mentally ill and deficient is an increasingly serious problem, and

"WHEREAS, the annual toll in human misery and in lost production is a great drain on State budgets and is constantly mounting, and

"WHEREAS, there is no other major governmental activity which is so singularly a State responsibility, and

"WHEREAS, there are not enough trained people to use the knowledge that we already have, and

"WHEREAS, there are many patients in hospitals today who could be returned to productive lives if available treatments could be given them, and

"WHEREAS, we need more knowledge, and

"WHEREAS, research provides spectacular beneficial results, and

"WHEREAS, a cooperative and coordinated effort can be established among various State agencies dealing with this problem to expand the training and research program in this State, and

"WHEREAS, such a program will provide adequately trained personnel and knowledge to cope with this problem, and

"WHEREAS, such a State project will be part of the expanded program of the sixteen Southern states and ten Northeastern states' work, and

"WHEREAS, the Governor's Committee on Mental Health Training and Research has developed exhaustive reports on local needs and resources in mental health training and research, NOW, THEREFORE,

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE

Section 1. The sum of $120,000.00 is appropriated for the biennium beginning July 1, 1955, and ending June 30, 1957, to establish a coordinated program of research and training throughout the State by improving personnel and facilities for research and training at various Delaware Institutions.

Section 2. The State of Delaware, through appropriate officers shall seek in addition to the present arrangements with the University of Pennsylvania, similar formal arrangements with Maryland, North Carolina, and Virginia for the training of personnel in psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing on graduate level until adequate facilities for this purpose can be provided within the State:

The Governor Bacon Health Center is offered as a regional facility for training of child psychiatrists, clinical psychologists, and psychiatric social workers.

Arrangements shall be effected with other states by which the Governor Bacon Health Center may assist other states in residential treatment of maladjusted children inasmuch as this type of facility is lacking in most of the other Southern states.

Delaware will coordinate with other states engaged in similar treatment, its research in the study of cerebral palsy and other spastic diseases of children.

Delaware will coordinate with other states its research in the study of alcoholism by using its existing facilities at the Governor Bacon Health Center.

Delaware will increase the scope of its present research in schizophrenia, alcoholism, geriatrics, and personality problems in children.

Section 3. The Governor is authorized to establish a Special Board, composed of ten men and women from the Governor's Committee on Mental Health Training and Research, and four members of the General Assembly, two from the House and two from the Senate, to assume the responsibility of approving research projects and allocating funds. This committee will be under the chairmanship of the State Psychiatrist of Delaware.

The Board so appointed shall report its progress to the Governor not later than January 1, 1957, and make this report available to the 119th Session of the General Assembly in 1957.

Section 4. The said Board shall be empowered to seek Federal, Private and other Grants considering the State Appropriation of $120,000.00 as a nucleus for enlargement of the program of Research and Training.

Section 5. This Act shall be known as a Supplementary Appropriation Act and the funds hereby appropriated shall be paid by the State Treasurer upon warrants of the proper officials of the Special Board, out of the General Fund of the State of Delaware."

The passage of this bill will open a new era for mental health in the state of Delaware. We are very grateful to the Governor and the General Assembly and to those who supported this bill.

(continued from page 196)

Sally clearly divorced herself from this kind of adventure: "I never met a girl like this". (13) During discussion of suitable marriage age, looked forward to being 18, emphasizing again her desire to be married immediately after release. Made sure that the other girls knew of her having had sexual intercourse with her boy friend during Christmas vacation, thus gaining status among them who previously looked down at her as a virgin. Expressed rather immature interests in that session, for instance, how she evaluates the character of boys from the way they dress, whereby "sharp" dressing is in her highest esteem. (18) Discussion of careers. Sally has given up any idea of preparing for a job, knew that the boy friend was accepted by both parents and the School administration. (20) Having obtained more prestige in the group, her suggestions were accepted and her opinion carried some weight. During a discussion of two types of young people, namely, "church kids" (who are

boring) and "us" (who are more lively), Sally protested against such a distinction, saying, "we go to church too". (22) Wore her new engagement ring and was too absorbed in writing a letter to her fiance to participate in the discussion. (23) Topic: smoking. Sally believed that she had acquired the habit at age 9 without too much protest from the family. (24) During a critical discussion of staff, Sally was more specific than she used to be. Did not express overall hostility (like the "junior workhouse" remark of several months ago), but only protested against a snickering remark which one of the cottage mothers had made regarding her stiffness from horse-back riding on weekend leave. (25) Knew for sure that she will be married in June. Took lively interest in the future of another less fortunate member of the group whose release from the School was problematic, as she had no place to go. (27) Discussion of religions: tried to stress similarities beside the differences. It was suggested that girls from the "back woods" be invited to join the group. Intention to ridicule the latter and to show one's superiority was obvious among some of the girls; Sally suggested that these "back woods" girls should rather be helped. (28) Various "Life Adjustment Booklets" were brought along for possible use by the group. Sally selected one, "Understanding Sex", and the group was quite pleased when she volunteered to read. (29) Too disturbed to read in this session; believed to be pregnant and feared mother would withdraw permission to marry her fiance. (30) Fear of pregnancy proved to be unjustified. In this session girls began to pick on a fellow-student (not a member of the group) whom they universely rejected in very drastic language. Sally at one point emphasized this girl's assets: "She could be smart in school if she tried". (31) Three weeks before Sally's wedding. Volunteered to take notes on the proceedings of the session. In discussion, stressed the positive aspects of life at the School, how it had helped her in her physical well-being, and how it had taught her to dress according to her age rather than like an adult woman. Keeping notes of the proceedings probably signified identification with the adult world of the therapist into which she was going to move.

DISCUSSION

The detailed description of this sample case has been offered to demonstrate how group therapy supplements and mirrors institutional life, and vice versa.

Sally W. has gained considerable insight into her personal problems. Her confusion about divergent standards for sex conduct as expected by the church on one hand and by certain of her peers on the other hand has given way to clearer thinking and compromising. A more wholesome attitude toward and better understanding of the adult world which she was about to enter was noticed. She was able to decide in favor of a comparatively worthwhile marital partner, while previously she had desired marriage with anyone who proposed first.

Detailed "success stories" could be continued here if space permitted. Briefly here are a few: The case of Helen K., already married when committed, who has now settled down, becoming a real housewife and helping her husband to curb his drinking habit; Phyllis F., who for the past six months has been living away from her conflicted, unstable parental home, has been making her living as a nurse's aide, and on her own continues to search for self-improvement by undergoing individual psychotherapy; Katherine M., who has been reconciled with her parents, has given up her unsuccessful high school work and is employed as a luncheon counter girl in one of the dime stores.

And then, of course, there are our failures: e.g., Fanny G., the homeless girl and perpetual foster child who profusely verbalized her feelings in the group; twice withdrew from it and came back, but recently escaped from the School; at the time of this writing, she is A.W.O.L., probably "bumming around" in the city. It is probably difficult to classify Mary K. either as a failure or as a success. This bewildered and disturbed girl of limited intelligence escaped three times

during the period of her group membership and was returned each time, was not apprehended after her fourth escape in February. Prior to her commitment to the School at the age of 15, she had given birth to an illegitimate child. Recently, she contacted the School administration, pregnant again, but married to a 19 year old man whom she has known for many years, who is responsible for this pregnancy and seems to be truly fond of her.

Group psychotherapy is no panacea. Its effectiveness depends upon numerous factors of which intensity is an important one. All parts of a training school program (education, recreation, individual and group therapy) are most effective if they are carried out by resident staff members who at least during day hours are available to the youngsters whenever the need arises. Therapies by "imported" specialists, while certainly enriching the program, do not suffice. The many failures on parole are not only heartbreaking to the families but also costly to society. Therapy ideally should be conducted by those who are in permanent contact with the youngsters. This implies that more advanced training and better remuneration for institutional workers should be our next goal.

THE PROBLEM OF SYMBOLISM AND THE USEFULNESS OF GOLDSTEIN'S THEORIES IN RORSCHACH INTERPRETATION

FRED WISSNER, Ph.D.,*
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In discussing the problem of schizophrenia Sullivan[5] spoke of these patients' tendencies to misinterpret phenomena in an over-complex manner while the simple interpretation of stimuli more adequately explained or more closely approximated reality. Sullivan mused over the schizophrenics need to complicate the preception of reality when the simpler appercept proved much more appropriate. Within a theoretical framework similar problems face the clinical psychologist or psychiatrist in their contention with interpretation of data as presented. While a dual instinct theory may manifestly represent a means of simplifying and explaining human nature, (perhaps that is why the theory is popular) tendencies are to become inveigled in complex super structures which are designed to explain dynamics but tend to encumber themselves with theoretical appendages which do not necessarily fit into the theory proper, but which are necessary if the theory is to be workable (e.g., collective unconscious).

In Rorschach interpretation the worker generally assumes a theoretical point of view and evaluates his data from this framework. To the dynamically inclined Rorschach worker the use of the symbolic interpretation plays an important role.

The problem in the use of symbolism becomes quite meaningful, however dangerous, if one were to examine the handling of it in Rorschach interpretation. In an attempt to simplify interpretation of a protocol ofttimes the examiner may assume the existence of a "mother" and "father" card, whereupon any projections onto these blots presumably represents attitudes towards parental figures. With such leaps in thinking tendencies are to reify the blots themselves. A simplified explanation, or more adequate working hypothesis, of the "mother" and "father" card phenomena, if it exists, is that the intrinsic qualities of the blots elicit material relevant to father or mother. The blot by itself does not represent parental figures, rather the whole cultural kaleidoscopic percept of what father or mother represents may stimulate in the patient associations relevant to parental figures.

At one level cultural and biological dictates suggest the male to be the more angular, bulkier, "harder", of the means. On the other hand, the female is thought of as softer, curvacious, and more graceful. The blots' latent intrinsic qualities may be bulky, hard, or soft. This would imply the blots are not as unstructured as they might seem and that deviated apperceptions on the part of the subject represents his own inner distortions or deviations from societal-biological constructs of what represents feminity or masculinity. With such a viewpoint there

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is less need to "reify" the inkblots; at the same time robbing the interpretations of their mystic qualities, and affording a simple logical explanation of a subject's apperceptions.

An uninitiated or naive Rorschach worker can carry Brown's[1] concepts to an extreme in attempting to reify specific areas of the inkblots, assigning meanings to them. Brown is careful to point out however that blots and blot areas do possess certain intrinsic qualities relevant to eliciting certain responses at unconscious levels. Deviations from these "assigned" qualities represent the apperceived distortions on the part of the patients. Suggestions are that blot segments are so intrinsically constructed as to elicit particular responses. In part this tends to question the notion that the Rorschach is an "unstructured" test, rather it is unstructured to the subject who does not "know" consciously what is expected, but it tends to be highly structured at deeper levels.

The problem of the W compulsion has confronted this examiner by the nature of the population that he has worked with. The W compulsion is the need to organize the total blot as though all parts *must* necessarily go into a complete whole together. The patient cannot see fit to associate to only one segment of the blot, rather tendencies are to reify the blot and assume one must "give an answer" to what the blot means. Such behavior is adequately explained by Goldstein's[2,3] concepts of abstract and concrete thinking. The sick organism, in his failure to abstract, does not "realize" not only that he can associate to parts, but also the parts can represent or elicit associations relevant to various phenomena. The sick organism tends to feel the blot is "the thing" (loss of distance) or that only one response to an area is possible. By his concrete thinking he tends to reify and apperceives the blot as the concept he associates to it. A loss of distance may be the end product of such pathological thinking. The Goldstein theory of concrete and abstract behavior is thus graphically illustrated in Rorschach projection. Other theoretical frameworks may merely describe the phenomena or complicate the explanation of the dynamics of the phenomena through highly complex gyrations.

For example, take the problem of fabricated combinations as seen on the Rorschach test. A pathognomic sign is the perception on Card X, D4, as two caterpillars crawling through the eyes of a rabbit. While both blots of ink lie close to one, another (the caterpillars and the rabbit's head) Shaefer[4] argues that since one does not see such grotesque concepts in everyday life this is indeed a sick response. While descriptively this is true, Goldstein's concepts prove useful in revealing a more dynamic picture. Such a percept reveals the patient tends to be concrete and is blot bound, unable to abstract the blots as separate entities and associate to them. While the areas of ink are in close proximity the healthy individual is not bound by such closeness and is able to see alternatives in giving a more meaningful responses to stimuli. In his concreteness the sick organism becomes morbid; he sees the world as possessing malignant qualities, at the same time he is played upon by the outside which he cannot manipulate. Through his concreteness the blots become his master while he may feel a loss of "will" or ability to handle the environment.

For illustration, another case in point is Card VIII, D1, the popularly seen animal figures. The sick organisms may respond "those are red animals." The blots of ink are in fact red if the examiner wishes to inspect them. Nevertheless the response is inappropriate even though the blot quality corresponds to the patient's association.

An examiner steeped in Freudian thinking may explain such a response by suggesting defective repressive defenses. True the blot is red, but who sees red animals? Such postulations infer a need for healthy defenses and a need to repress non-germain data. It would appear once again that Goldstein's concepts tend to simplify the evaluation of such a response without the need for over-postulation.

The organism apperceiving a red animal is showing inappropriate behavior not only by being stimulus bound (concrete) but he is unable to abstract and associate the blot area with an animal he has seen in his world of reality. This ability to associate implies abstract thinking in which appropriate behavior would ensue. As an added feature Rorschach speaks of color as reflecting the handling of affective energies. With an impairment of abstract thinking this inappropriateness may reflect difficulties with one's affect.

To cite a third example, Card III, D1, is generally seen as two human figures. Inspection in this area reveals the "upper" and "lower parts" of these "humans" are not connected on the ink blots. In a "good" perceptual response the subject would "ignore" this facet of reality and speak of this area as "a human being." Perhaps a Freudian worker would consider this a healthy defense mechanism of rationalization, in order to give a meaningful response. In such a response the patient would not actively concern himself with the objective fact that parts of the figures are separated.

Goldstein's view that the patient seeks order through his ability for abstract thinking once again tends to simplify the cumbersome theoretical superstructure of defenses, etc. The configuration of the blot area gives rise to associations relevant to human beings in a patient's life. Through the process of abstracting he is able to draw from his own experience and perceive a "gestalt" or meaningful totality. He is not stimulus bound and does not allow the ink blot form to dominate his percept. Rather there is a unique interplay of stimulus and subject with the subject manifesting a versatility in the use of symbolic thought processes.

Goldstein theory in part is designed to explain human behavior largely through its biological makeup, at the same time refuting the validity of instinct theory regardless of such theory's workability. An applicability of this theory to Rorschach interpretation is suggested as a means of understanding the conceptual process as well as a means of simplifying interpretation and making such interpretation more clear.

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COMING MEETINGS

Saint Francis Hospital

Obstetrics and Gynecology Conference—Every Wednesday 8:00 A.M.

Medical Conference—Third Wednesday 10:00 A.M.

Surgical Conference — Third Tuesday 8:30 A.M.

Wilmington General Hospital

Medical Conference—Second and Fourth Saturday 8:30 A.M.

Surgical Conference — First and Third Wednesday 8:30 A.M.

Memorial Hospital

Medical Conference — Every Tuesday 8:30 A.M.

Tumor Conference—July 13-July 27 and August 10 and 24, 12 noon.

Obstetrics and Gynecology Conference—July 6 and 20, 12 noon.

Surgical Conference — Every Saturday 8:00 A.M.

Delaware Hospital

Urology Conference—Every Wednesday 8:00 A.M.

Medical Conference — Every Thursday 8:30 A.M.

Surgical Conference — Every Saturday 8:30 A.M.

Tumor Conference—July 6 and 20, August 3, 17, 31, 12 noon.

Neuro Surgery Conference—July 13 and 27, August 10 and 24, 12 noon.

Beebe Hospital Staff Meetings—1:00 P.M. —Lewes—July 15, August 19.

Nanticoke Memorial Hospital Staff Meetings—Seaford—12:30 P.M. July 7, August 4.

Milford Memorial Hospital Staff Meetings 4:30 P.M. July 12, August 9.

MEDICAL SOCIETY OF DELAWARE
Delaware Academy of Medicine
WILMINGTON, DELAWARE
MONDAY, OCT. 17, 1955

3:30 p.m.—Registration of Delegates.
4:00 p.m.—House of Delegates Meeting.
6:30 p.m.—Supper for Delegates.

8:00 p.m.—Registration. General Meeting.

8:30 p.m—Invocation, Rev. Alfred R. Shands, III, Holly Oak.

8:35 p.m.—Welcoming Remarks — Norman L. Cutler, M.D., President, New Castle County Medical Society; Victor D. Washburn, M.D., President, Delaware Academy of Medicine.

8:40 p.m.—Presidential Address — Lewis B. Flinn, M.D., Wilmington; The Medical Society of Delaware.

9:00 p.m.—Panel Discussion: Vitamins and other Nutrition Factors in Clinical Practice.
This Panel will concern surgeons, obstetricians, pediatricians, etc., as well as internists and general practitioners.

Moderator—LEWIS B. FLINN, M.D.

Robert S. Goodhart, M.D., Scientific Director, National Vitamin Foundation, New York; Winslow Tompkins, M.D., Obstetrician, Jefferson Medical College, Philadelphia; Robert G. Ravdin, M.D., Assistant Professor of Surgery, University of Pennsylvania; Robert Kaye, M.D., Assistant Professor of Pediatrics, University of Pennsylvania.

10:30 p.m.—Adjournment — Refreshments.

TUESDAY, OCT. 18, 1955

9:00 a.m.—Registration. General Meeting.

9:30 A.M.—Report of House of Delegates, Secretary Norman L. Cannon, M.D., Wilmington.

9:40 a.m.—Prolonged Survival in Malignant Lymphoma, John F. Hynes, M.D., Wilmington, Consultant, Tumor Service, Memorial Hospital.

10:00 a.m.—Stein-Levinthal Syndrome: Preliminary Report, Oscar N. Stern, M.D., Wilmington. Chief in Obstetrics-Gynecology, Delaware and Memorial Hospitals.

10:15 a.m.—Exhibits.

10:45 a.m.—Panel Discussion: Current Concepts of Virus Disease in the Delaware Area.
This Panel will include hepatitis, poliomyelitis, psittacosis, mumps, and a new group of R.I. virus diseases.

Moderator—LEWIS B. FLINN, M.D.

Floyd I. Hudson, M.D., Executive Secretary, Delaware State Board of Health; Joseph Stokes, M.D., Professor of Pediatrics, University of Pennsylvania; Werner Henle, M.D., Professor of Virology, University of Pennsylvania; Maurice Hilleman, Ph.D., Assistant Chief, Department of Virus and Rickettsial Diseases, Army Medical Service School, Washington; Dorothy Horstmann, M.D., Associate Professor of Preventive Medicine, Yale University.

12:15 p.m.—Election of President — elect for 1956 (New Castle County).

12:30 p.m.—Adjournment — Exhibits.

1:00 p.m.—Luncheon, as guests of the New Castle County Medical Society.

2:00 p.m.—Recent Concepts in the Management of Staphylococal Infections, William J. Holloway, M.D., and Elvyn G. Scott, M.T., Wilmington, Assistant in Medicine, and Bacteriologist, Delaware Hospital.

2:15 p.m.—Antibiotic Therapy of Skin Diseases, Lawrence Katzenstein, M.D., Wilmington, Dermatologist, Delaware, Memorial, and Wilmington General Hospitals.

2:30 p.m.—The Home Care Program and Other Aspects of Long-Term Illness, Ruth B. Freeman, R. N., Associate Professof of Public Health Administration, Johns Hopkins University.
Discussion: Victor D. Washburn, M.D., Richard Griffith, Edgar Hare, Jr., Wilmington.

3:10 p.m.—Exhibits.

3:40 p.m.—Panel Discussion: Recent Trends in the Management of Vascular Disease.
This Panel will include cerebral aneurysms, surgical and nonsurgical management of arterial and venous thrombosis, prevention of rheumatic heart disease, cardiac surgery, cerebral vascular insufficiency.

Moderator—LEWIS B. FLINN, M.D.

John P. Hubbard, M.D., Professor of Preventive Medicine, University of Pennsylvania; Henry T. Bahnson, M.D., Associate in Surgery, Johns Hopkins University; Samuel B. Hadden, M.D., Associate Professor of Psychiatry, University of Pennsylvania; Livio Olmedo, M.D., Neurosurgeon, Wilmington; G. Barrett Heckler, M.D., Internist, Wilmington; Charles P. Bailey, M.D., Professor of Thoracic Surgery, Hahnemann Medical College; Harry T. Zinsser, M.D., Robinette Foundation, University of Pennsylvania.

5:15 p.m.—Adjournment — Exhibits.

Hotel duPont

6:45 p.m.—Reception — Georgian Suite.

7:30 p.m.—Annual Dinner, duBarry Room. Members and Auxiliary are invited to subscribe. Tickets from Dr. Charles Levy, 621 Delaware Avenue, Wilmington — Dress: optional.

Invocation — Rev. J. Seymour Flinn, Wilmington.

Toastmaster—LEWIS B. FLINN, M.D.

Citations of 50 Year Members.

Introduction of Distinguished Guests.

Address—Edward L. Bortz, M.D., Past President, A.M.A., Philadelphia.
— Significant Trends in Medical Education

WOMAN'S AUXILIARY, M. S. OF D.
du Pont Country Club
TUESDAY, OCT. 18, 1955
Mrs. Gerald A. Beatty, President

9:30 a.m.—Registration.
10:00 a.m.—Business Meeting.

12:30 p.m.—Luncheon. Guest Speaker: Mrs. C. R. Pearson, Chairman, Nurse Recruitment, Woman's Auxiliary to A.M.A.
Installation of Officers: Mrs. Pearson.
Inaugural Address: Mrs. Richard W. Comegys, Clayton.

Hotel duPont

6:45 p.m.—Reception and Dinner (Subscription)

MISCELLANEOUS

Genetics May Change Man

Man has within his grasp more power to change future generations through breeding than he has wisdom to direct changes for the best results.

An editorial in the August 6 *Journal of the American Medical Association* said genetics, the science of heredity, offers the possibility of changing the race. However, no means for improvement of human stock has yet been devised.

There are many difficulties, resulting largely from the complicated behavior of genes, the biological factors which determine heredity.

For instance, it may be possible to control one gene, but it is hard to tell how it will be influenced by other genes. In other words, the effect of a gene may depend on "the company it keeps."

Another problem is the inability to predict long-term results of manipulating genes.

"Selective breeding," as used in cattle, has been suggested as a method of improvement, but this is not likely to gain wide acceptance because of the "violent emotional reactions such proposals automatically arouse."

"The widespread use of a 'perfect donor' through artificial insemination might lead to too great a uniformity in a world where diversity is still highly desirable," the editorial said.

In addition, such a donor might spread hidden bad traits through a large segment of the population before they could be detected. Inbreeding, as has been shown in the past by various royal families, brings hidden traits into the open. "If these are harmful, as they are more often than not, inbreeding will increase the number of persons afflicted," the editorial said.

The proportion of persons with mental and physical defects is increasing in modern civilization because advances in medical science make it possible for them to live longer, the editorial said.

None of the measures advocated to prevent degradation of human stock, such as sterilizing mental defectives, have "made more than a feeble impression on the problem as a whole."

While physical traits are more nearly determined by heredity, they are less influenced by environment than are mental traits. "Social traits or personality, although affected by heredity, are altered by environment with the greatest ease."

The editorial concluded, ". . . it is easier to define good environment than good heredity. So far, the power to change man genetically exceeds the wisdom needed to know in what direction genetic controls should be applied to achieve the best results."

U.S. Becomes 'Medical Magnet'

The United States has become a "medical magnet" for physicians in Europe, Asia, Africa, and Latin America.

More than 5,000 foreign physicians came to this country during the year 1954-55 for study, according to a survey by the Institute of International Education and the A.M.A.

They came from 83 different countries for internship and residency training at hospitals in 42 states, the District of Columbia, Hawaii, Puerto Rico, and the Canal Zone.

The survey of 1,177 hospitals, among those approved for internships and residencies by the A.M.A., indicated that there were at least 5,036 alien physicians in training. Not included in the study were immigrants and displaced persons.

Individual countries sending the most physicians were the Philippines, Canada, Mexico, Germany, and Turkey. Of the major geographical areas, the Middle, Near, and Far East had the largest representation.

Of the total, 620 or 12.3 per cent were women. In comparison, women made up only 5.2 to 5.7 per cent of American medical school graduating classes in the years 1952 through 1954. Over half of the women came from the Near, Far, and Middle East, with the Philippines sending the most.

More than 2,000 of the physicians were in the United States on their own resources. Others were sponsored by at

least 67 different agencies, including their own or the United States government, the United Nations, and religious, educational or philanthropic organizations. Many were sponsored by the hospitals in which they were training.

In addition to the large number of physicians in hospital internship-residency training, others visited this country as observers, professors, or guest participants in research. They represented 21.5 per cent of all foreign educators who visited the country during the year.

In comparison, only 3.6 per cent of all American educators visiting other parts of the world in 1954-55 were listed under medicine.

The survey was reported in the Aug. 13 *Journal of the A.M.A.* by Dr. James E. McCormack, associate dean of graduate studies at Columbia University and Arthur Feraru, head of the Central Index and Census Division, Institute of International Education, both of New York.

The causes of health and therefore the factors important to its evaluation and management are often to be found in the individual's personal and community environment. Ward Darley, M.D., J.A.M.A., April 30th, 1955.

* * *

All tuberculous patients exhibit one reinfection after another, for by its nature tuberculosis is a metastasizing infection, be it through bronchi, lymphatics, or blood stream. E. M. Medlar, M.D., Am. Rev. Tuberc., March, 1955.

* * *

Some chronic conditions are preventable; some are deferable; some are curable; and some are modifiable. We know how they are spread and how to prevent their spread. Some conditions, such as diabetes or rheumatic heart disease, are deferable even where there is a tendency toward it, if the appropriate medical care is provided in time. Some conditions, such as pernicious anemia or cerebral hemorrhage, are modifiable. Daniel Bergsma, M.D., New Jersey, Pub. Health News, April, 1955.

A good chest X-ray screening program in a general hospital can make possible better medical care, as well as supplying added community service. It will lessen the health hazards to patients and to hospital staff. It will insure better employee health programs. As a resourceful means for the earliest possible detection of unsuspected thoratic disease, it should be a saving for both the hospital and its patients. Theodore L. Badger, M.D., Bull. Nat. Tuberc. A., June, 1955.

* * *

Tuberculosis is still a communicable disease; isolation in a tuberculosis hospital is an essential factor in tuberculosis control. There is need for hospitalization because many cases of tuberculosis have a positive sputum for many months even with intensive chemotherapy. There is need to evaluate each case on an individual basis, and this can best be done . . . in the hospital in consultation with the thoracic surgeon. There is need for hospitalization during that period when sensitivity of organism and effectiveness of treatment are being tested. Paul S. Phelps, M.D., The John N. Wilson Memorial Lecture, April 30th, 1954.

* * *

We are doing a better job in reducing the tuberculosis death rate than in reducing the number of cases. At present the annual number of reported cases of tuberculosis is declining by only three per cent in contrast with a 20 per cent drop in the death rate each year since 1951. Last year is the first time in our history when tuberculosis did not rank among the first 10 causes of death. In spite of this good showing we have not won the battle against tuberculosis. We will not have won it until we achieve comparable success in reducing the large reservoir of tuberculosis infection still prevailing in most parts of the country. We can do this — but only through a continued and concerted effort to find and treat larger numbers of people annually in the early stages of their disease. Leonard A. Scheele, M.D., Bull. Nat. Tuberc. A., May, 1955.

BOOK REVIEWS

RECENT ADVANCES IN MEDICINE AND SURGERY (19-30 April 1954) Based on Professional Medical Experiences in Japan and Korea, 1950-1953. Medical Science Publication No. 4, Volume I and Volume II. Paper, Volume I, pp. 530; Volume II, pp. 421. Army Medical Service Graduate School, Walter Reed Army Medical Center, Washington, D.C., 1954.

These two volumes reflect the professional and clinical activities, problems encountered, and lessons learned by the Army Medical Service during the Korean War.

The clinical research and results outlined in these two volumes will be of value to physicians who will be called on to treat mass casualties, whether they be brought about by military or civilian disasters. We are given the benefit of information gained and clinical observations made by men on the scene in Korea and Japan, and their papers are arranged as they were presented in an organized course given in a two-week period at the Walter Reed Army Medical Center.

Particularly impressive are the Korean experiences in neurotropic viral diseases, especially Japanese encephalitis. It is of interest that no evidence was obtained demonstrating conclusively either the effectiveness or non-effectiveness of Japanese B encephalitis vaccine as an immunizing agent, using formalinized mouse brain vaccine. No specifically effective therapy was demonstrated.

The papers on "Fatigue and Metabolic Deficit", a study of combat stress, physiologic and biochemical (Vol. I, pp. 3-45) will be found illuminating. The point to emphasize is that we can learn a great lesson from the conclusion that "Fatigue was seldom due to physical hardships. Fatigue was due to continued emotional stress, and in part, to uncertainties. This is the fatigue which does not disappear with sleep and which has a cumulative effect." The urinary excretion of 17-ketosteroids, corticosteroids and eosinophiles, sodium, potassium, and water balance were studied under various conditions of stress.

These volumes are, of course, of extreme value to the military; however, many of the lessons learned would also benefit the general practitioner. A complete subject index would be of tremendous reference value.

CURRENT THERAPY 1955: LATEST APPROVED METHODS OF TREATMENT FOR THE PRACTICING PHYSICIAN. Edited by Howard F. Conn, M.D., Pp. 692. Cloth. Price, $11.00, Philadelphia; W. B. Saunders Company, 1955.

The physician finds himself deluged with new medical books, journals, abstracts, and summaries of abstracts. However, he will find Current Therapy 1955 a complete ready reference of tested therapeutic agents. Numerous authors and consultants have contributed. Diagnostic procedures are purposely omitted. There are fifteen sections covering diseases involving the various systems of the body. The last section contains a roster of drugs, tables of metric and apothecaries systems, tables for making percentage solutions, and indices of authors and subjects.

Of necessity, the treatment of each condition is brief, and bibliographies have been omitted. One must refer to other sources for detailed information on any subject.

One disadvantage of a book of this type is, of course, the lack of agreement by some of the authors on the usefulness of a drug or procedure. The use of curare in aqueous or repository medium is an example in point. Four of the authors found curare useful (pp. 189, 216, 513, 518), while two condemn curare agents as "dangerous drugs" and even state that "in its aqueous form, the margin of safety between the therapeutic dose and the lethal dose is dangerously small" (pp. 480 and 576).

Such statements are contrary to numerous clinical reports on the use of curare in many clinical conditions in hospital and office practice. It would be well for the authors to become more familiar with contemporary literature, so that the reader will maintain his faith in the title of the book.

Current Therapy 1955 should be a "must" addition in every hospital library. General practitioners will appreciate the easily available therapeutic suggestions.

CHRISTOPHER'S MINOR SURGERY. Seventh Edition, Edited by Alton Ochsner, M.D., Professor of Surgery, Tulane University, and Michael E. DeBakey, M.D., Professor of Surgery, Baylor University. Pp. 547, with 251 illustrations, cloth, Price, $9.00, Philadelphia; W. B. Saunders Company, 1955.

A number of outstanding surgeons have collaborated in the preparation of this book. When one thinks of minor office surgery, Christopher's book may always be relied upon for practical, simple, and well illustrated procedures.

Chapter 12 on Injuries and Their Management is an excellent summary on the management of strains, sprains, fractures, dislocations, etc., of the entire body. The general practitioner, the surgical resident, as well as the surgeon, will find this volume complete in such practical topics as office equipment, surgical considerations, dressings and bandages, anesthesia, resuscitation, and minor surgical procedures encountered with every system of the body.

References are given at the end of each chapter, and a complete subject index is given at the end of the book.

PROCEEDINGS OF THE THIRD MEDICAL CONFERENCE OF MUSCULAR DYSTROPHY ASSOCIATION OF AMERICA, INC. Paper, Pp. 234, American Journal of Physical Medicine, Vol. 35, No. 1, February, 1955, Baltimore: Williams and Wilkins Company.

This is a symposium dealing with the work of the Muscular Dystrophy Association in its efforts to bring together recent advances in muscle physiology and the management of this disabling disease. Most of the papers deal with muscle and nerve physiology, diagnosis, and treatment.

Unfortunately, there is very little that is new or spectacular in the reports. The physical rehabilitation phase in the management of muscular dystrophy is emphasized.

The medical management of contractures in muscular dystrophy is discussed, pointing out the uselessness of various drugs. Curare is not favored, but it was not tried on patients with muscular dystrophy.

This volume is not indexed; therefore, its practical reference value is greatly diminished. Many references are given at the end of each paper which is helpful bibliography for research workers.

While the material in this collection is not specifically intended for practicing physicians who do not handle this disease, the principles outlined in rehabilitation may be applicable to other neuromuscular diseases. Physiatrists and workers in rehabilitation centers will find this volume useful for general reference.

TEA: A SYMPOSIUM ON THE PHARMACOLOGY AND THE PHYSIOLOGIC AND PSYCOLOGIC EFFECTS OF TEA. Henry J. Klaunberg, Ph.D., Pp. 64. Paper. Price, $1.00. Sponsored by the Biological Sciences Foundation, Ltd., Washington, D.C., 1955.

Next to water, tea, known as a beverage since 2737 B.C., is the most consumed beverage in the world. The purpose of this publication is to begin an organization of research and clinical data on tea that will prove helpful to dietitians, nutritionists, and the medical profession in general.

The papers presented include: Pharmacology, Beverage and Dietary Aspects, A Medical Appraisal, Relief of Fatigue, Anxiety and Tension States, Psychological Effects of Drinking Tea, and Effects on Gastric Secretions and Motility of Tea.

Among the interesting facts brought out are that tea is of a negative nutritional value and it contains caffeine, theophylline, and theobromine, which produce a slight psychic stimulation and diuretic effect. The conclusion developed is that tea is a harmless beverage in health and disease, in all ages. In 1954, Americans drank 2.3 billion pounds of coffee or 14.7 pounds per capita, and 112 million pounds of tea or 0.69 pounds per capita. One pound of tea produces 200 cups of beverage, and one pound of coffee makes 40 cups of coffee beverage.

CONTENTS

SELECTION **PROTECTION** **INJECTION**

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Streptomycin Sulfate Solution—1 gram
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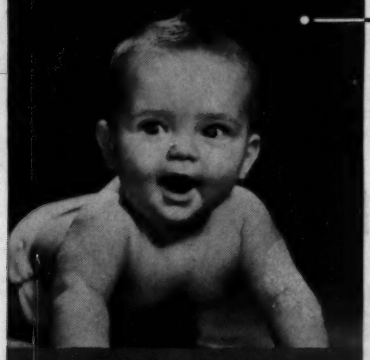
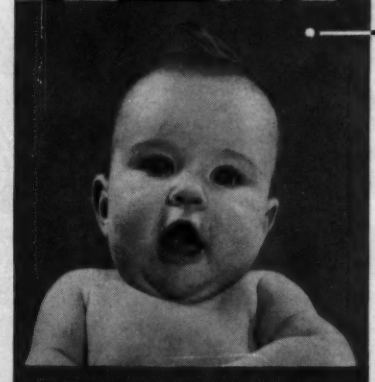
Why so many physicians SPECIFY PABLUM CEREALS

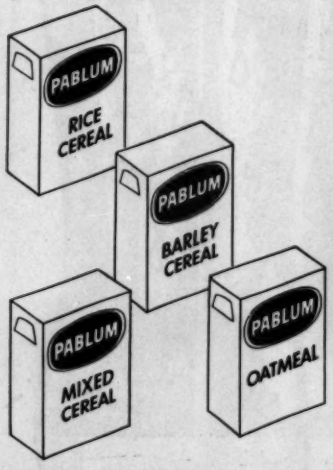


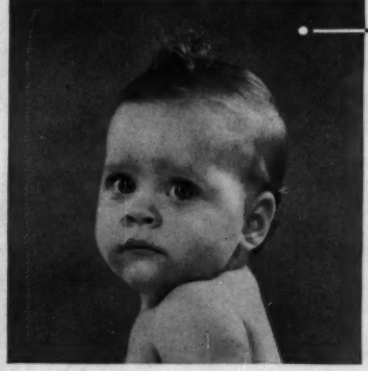
TOMMY started on Pablum Rice Cereal at the age of 2 months. He likes its smooth texture (all Pablum Cereals are smooth). Pablum Cereals give him plenty of iron—½ oz. supplies 4.2 mg.—to help prevent iron deficiency anemia.



MARY LOU likes Pablum Oatmeal. Since she has been eating Pablum Cereals her growing appetite is satisfied longer.

Pablum Rice Cereal
Pablum Barley Cereal
Pablum Oatmeal
Pablum Mixed Cereal





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